PROBLEMS AND POTENTIALS OF THE HANDICAPPED

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Edited by

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PREFACE

It is a troublesome task to carry out researches when there is paucity of resources. It is more difficult when one accepts the challenge of exploring something specially when very little is known in that area. The handicapped population occupies a similar position of a separate class in the society all over the world.

Handicapped of any category remained an unavoidable problem for the society since the very existence of the human-kind. This unending menace to the civilization was for the first time realised by the world body, United Nations, which recognised this universal problem by declaring 1981 as the International Year of the Disabled Persons (IYDP). According to the U.N. survey more than 500 million people in the world today cannot take full part in the ordinary activities of the daily life. They suffer from physical, mental, emotional or sensory *impairments*. Their inability to cope with personal and social demands compels them to a withdrawn life and an isolation from the mainstream. Thus these people are *disabled*. Their limitations prevent them from achieving what they themselves, their families and their communities expect. As a matter of fact, when a child is born disabled, everyone in the family is shocked, which in the long run becomes the source of depression for the family members.

In fact U.N.'s proclamation of the year 1981 as IYDP made the world community highly conscious regarding the problem of this neglected class of people who have just been treated as a burden upon the society. The focal aim of IYDP had been to provide an all round help to the disabled with regard to their social life and social security, economic upliftment, rehabilitation and protection from exploitation.

India was one among 21 nations who took an active participation in this respect, and went even further by preparing National Plan of Action for IYDP. India alone has some 60 million disabled persons in which physically and mentally handicapped occupy quite high percentage of this population.

The global efforts to help this suffering class with no fault of their own involved me to explore their *strong and positive points* which could be useful for them and the nation as well. Inspired by this I organised an interdisciplinary All India Conference on 'Psycho-Social Problems of the Handicapped' in 1982 sponsored by the University Grants Commission and Indian Council of Social Science Research. Besides the participants belonging to different disciplines quite a large number of psychologists, sociologists and social workers took part into the deliberations of the conference. The delegates both from India and abroad presented their papers.

This book is an outcome of this conference. There are seventeen papers included in this book out of which fourteen were presented in the conference and three were invited later. The book is divided into five sections. The first section presents an overview of different kinds of the handicapped, their social problems and the psychological consequences. This section also attempts to highlight various potentialities of the handicapped population. Suggestion for their rehabilitation and need for research have been emphasised. The second section deals with the problems and characteristics of the physically disabled, especially the orthopedics. All the four articles of this section have made a comparison between the two population, i.e., handicapped and non-handicapped. Section III explores the facts about the mentally ill and emotionally disturbed persons. This section has shown the problems of mentally and emotionally handicapped and also suggests the measures for curing mental illness. The IVth section of the book discusses the various issues involved in the upliftment of this class, i.e., disabled. The last section, V, is concerned with rehabilitation of different types of the handicapped, i.e., Social as well as Psychological, and suggests various measures in this direction.

I must express my gratitudes to our Chief Guest, Mr. Sita Ram Kesri, Hon'ble Minister of State, Government of India, who gladly accepted my invitation and took pains in coming and inaugurating the conference. I am equally grateful to Mr. A.J. Kidwai, Vice-Chancellor, Jamia Millia Islamia, for his patronage in holding this conference. I also express my sense of gratitude to Professor Ali Ashraf, Dean Faculty of Social Sciences, for his valuable suggestions. My senior colleagues, Dr. A.R. Saiyed and Mrs. Mohini Anjum, deserve my heartfelt

gratitudes for their kind cooperations. I am also thankful to Mrs. Sudesh Hemraj, Dr. S.M.A. Rizvi, Mr. Md. Talib and Mr. Md. Ishtiaque, Lecturers, for their help without whose support it was impossible to bring this task to a great success. I am much thankful to Mrs. Heather C. Hayden for her continued untiring help in the organisation of the conference. The youngsters, Mr. Zainuddin, Mr. Shahzad Hussain, Mr. Jawed Latif, Mr. Shakil Ahmed and Miss Arifa Kulsoom, deserve my whole hearted thanks for their round the clock support and cooperation. As a matter of fact they had been the pillar of success of the conference. I am also thankful to Dr. Anisur Rahman and Miss Sandhya Saxena who helped me in many ways. I must express my gratitudes to the participants of the conference and the contributors who took pains in writing articles on my request and presenting the papers in the conference.

Lastly, I thankfully acknowledge the help of Mr. Kalika Prasad Juglan and Mr. Shazi for typing assistance.

M.G. HUSAIN
Jamia Millia Islamia,
New Delhi-110 025
15-3-1984.

Text of the Inaugural Address of

Mr. Sita Ram Kesri—

"The disability of any kind is the real problem of a society. The emotionally disturbed, mentally ill, physically handicapped and socially deprived or destitutes are the real problems of our society today. They are also one amongst us who need our love, sympathy, support and cooperation in their lives.

The problems of the handicapped are not the problems that are exclusively confined to them only. Since the society has not accepted them sympathetically their problem has assumed larger and alarming proportions. Our social attitudes, stereotypes and prejudices have led to this state of indifference.

There is none in the world who is totally able and none who is totally disabled. We all have certain things that we can do well and certain things which we can't do equally. The handicapped, like us, are full of vigour, potentials and abilities which need proper exploitation in a right direction for a better utilization. Thus these are, in fact, not the real problems but only a social myth which must be eradicated collectively".

March 16, 1982.

Text of the Presidential Remarks by

Mr. A.J. Kidwai—

"Talent is not limited to robust and attractive personalities but in fact, the disabled or deprived have also equal potentials. It is widely considered that *disability* is commonly confined to physical deformities only. But this includes mental, emotional, and psychological disabilities and social deprivation as well. Handicap of any kind is not the problem of disabled but a responsibility of the entire society. The concern with disability is not only the problem of prevention and treatment but also awareness about the potentials and talents. We have tremendous responsibilities to make sure that this attitude is imparted not just to other specialists, but to all we come in contact with. We all have a unique role to play for the future of the disabled in India. It is the role of psychologists and sociologists to discover, understand and evaluate the abilities and disabilities of the handicapped and it is the role of the social workers, educators etc. to utilise this knowledge for the upliftment of this population. In fact Jamia has shown its deep concern to help them in many ways. The starting of new courses for the disabled is a step in this direction. The holding of this All India Conference is also an ample proof of involvement in a worldwide acknowledged problem. I feel that the problem of the handicapped is a social one which must be shouldered jointly by every section of the society which would help the people, the society and the nation to utilise the talents, skills and potentials of the disabled".

March 16, 1982

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Section I

Psycho-Social Dimensions of the Handicapped

Introduction

It is yet to be ascertained who is perfectly normal and who is completely handicapped. The year 1981 was declared the International Year of the Disabled Persons. Besides so many other things, IYDP has reminded us the handicapped heroes who reached the height of human glory in human destiny by combating their handicaps. Milton, the poet, was blind, Ustad Isa, the architect of one of the greatest monuments in the world, the Taj Mahal, was also blind, Taimur, the warrior, was a lame, Neopolian, also a warrior, was a dwarf.

Though late, the world has ultimately accepted the worth of those who face a lot of problems in their lives due to their some sort of limitations or disability. A disability is the lack or loss of a function or a capacity imposed by disease, accident or due to inheritence. The term disability is synonymous with handicap which has certain psychological overtones. In real sense the severity of disability determines the handicap. Illness or disability is not only a physical phenomenon with accompanying psychological features, it prevents the persons from performing average of customary social roles. In general disability is of two kinds—physical and mental. The former includes the blind, the deaf, the dumb and the orthopedics. However, four broad categories of the handicapped have been discussed. They are physical, mental, emotional and socially disadvantaged. Handicap of any sort is very much dependent upon social roles. Society's attitudes place the handicapped in subordinated status in some ways like ethnic minority groups (Tenny, 1953). Tenny observes that the attitudes of the majority are added encumbrances to the objective limitations of disability. The disabled person has the latter limitations, the one imposed on him by society and the self imposed ones

that arise from accepting the status conferred by society. Disabled are treated as having stigma. A stigma, purely from the psychological point of view, is preceded by three stages in human relationship—prejudice, discrimination and segregation or isolation. Among these stages prejudice is an important factor which governs the concept of physical fitness and leads the handicapped confronted by discrimination, hostility, indifference etc. Eventually the disabled persons tend to withdraw from interpersonal and community transactions.

The first section of this book has only one paper by M.G. Husain. This paper is informative, innovative, revealing, challenging and directional. Besides describing the aims and objectives of IYDP and National Plan of Action by the Government of India Husain has discussed a number of social problems the disabled population faces. Social stigma and prejudice have added more to this feeling. According to him a number of personality and adjustment problems of the handicapped are due to the society's unfavourable attitudes they encounter. These lead to maladjustment, isolation, withdrawal and many other psychological impairments. However, this paper by Husain highlights a number of positive points of the physically handicapped. As evident from the supporting literature their motivation, aspiration and number of mental capabilities are in no way inferior to those of their normal peers. However, their personality characteristics and adjustment were reported to be adversely affected by the disabilities. This paper also shows the debilitating effects of ill society, unstimulating environs and poor ecology on the overall psychological growth of the individuals. Lastly, the paper emphatically stresses the need for research on the problems of the handicapped. He also points out the acute needs for the rehabilitation of different categories of the handicapped.

Problems and Potentials of the Handicapped—A Social Psychological Interpretation*

M.G. HUSAIN

The world of the affluent and privileged hardly looks into the problems of those who are deprived due to one reason or the other. It is more difficult to pay attention to those whose whereabouts are little known. Among such deprived class, handicapped people occupy an important position, who deserve more and more care and attention for their upbringing, upliftment and adjustments to day-to-day life problems. To a great extent, various psychological growths are dependent upon environmental conditions, cultural taboos, social norms and family structure. Normally a healthy family and a sound and fair culture as well as the environment contribute quite positively to the healthy growth of the children against a sick and poor environment of broken home, low economic condition and illiteracy which show an adverse impact upon such psychological growth. This is more in the case of those who have some disability or deformity. A birth of disabled child is considered to be a curse for the family and is not well received. Not only this, the disabled child becomes a (source of) blemish on the prestige of the family. Some parents try to hide the disabled child from others as a matter of fear of non-acceptance by the community.

Disability, either innate or acquired, due to one reason or

*Largely based on the Keynote Address of the All India Conference on Psycho-Social Problems of the Handicapped held in Jamia Millia Islamia, New Delhi, March 16-17, 1982.

the other, not only proves to be a menace to the growth of the people but develops a feeling of compensation and hence creative productions in many walks of life. But his section of the society (disabled) form the sizeable chunk of the population. However, the perception of their own shortcomings as well as the treatment they receive from the society compels them to lead an isolated life with a limited sphere of movement. Those limitations might be due to various reasons such as disability, low income, poverty, and culture as well as social deprivations.

The long history of mankind has for the first time witnessed the concern of affluents, normals and developed ones to those who are deprived, disabled, and neglected. These disabilities and deprivations are the root cause of the injustice and negligence this section faces. The effect of such treatment has a two-fold impact. On the one hand is the development of a number of psychological problems such as maladjustment, mental, personality disorder etc. while on the other, the withdrawal from day-to-day social activities. Not only this, they pose a serious problem to the society and are a burden upon the family.

The problems of the normal itself are no less. Normal population has always been the focus of attention of the society, Government and other organizations. This interest among normals have over-shadowed the problem of the handicapped, who have always been ignored either knowingly or unknowingly. Normals are provided with many opportunities to improve themselves and to compete successfully in the competitive world. The children with some deficiencies, on the other hand, have always been the victim of negligence and criticism. It has been seen that many people, social organizations, national and international agencies have talked more about the welfare of the disabled and did little. This is for the first time in the history of civilization that an 'international war' has been launched against the sufferings and discriminations the handicapped are facing. India is one among the many countries, who have actively participated in this 'global effort' to 'know and help' the disabled population by declaring the year 1982, as the 'National Year of the Handicapped'. Recognizing this global problem, the U.N. declared 1981 as the IYDP.

Dr. Kurt Waldheim, former secretary-general, United Nations, had emphasized that the General Assembly, by

proclaiming 1981 as the 'International Year of the Disabled Persons', "aimed at focussing attention on the enjoyment by disabled persons or rights and opportunities in order to insure their full participation and integration into society. The efforts to find solutions to the problems of disabled persons should be an integral part of national development strategies".

Among many national and international bodies the UNICEF took special interest during the IYDP to promote and support more effective *measures* for the prevention of childhood disabilities; to encourage more positive attitudes towards disabled children; to aid the further participation and integration of disabled children in society; and to further the development of rehabilitation programmes. A rough survey disclosed that some 500 million people in the world today cannot take full part in the ordinary activities of daily life. They have physical, mental and sensory impairments. Their bodies have missing and defective parts. They are paralysed, have limited hearing, sight or mental capacity. Some have emotional difficulties, at times quite serious. These people may become disabled—that is, they may experience difficulties in moving, eating, seeing, speaking, hearing or learning. These limitations can also prevent them from doing what they, their families and their communities expect.

One child in ten is born with an impairment or acquires it—these children become blind or deaf, are mentally retarded, or physically limited. Most of these children, as well as most disabled adults by and large do not receive even the basic rehabilitation assistance, the combination of treatment, education and training that will help them to use their capabilities to the maximum. This is specially true of the 120 million disabled children living today in most of the developing countries of the world. The developed nations, on the other hand, do not have a very high number of disabled children as well as adults. They, by any means, not only manage to prevent the birth of such population but manage to alleviate the disabilities to a great extent. India, as against the developed nations, has some 60 million disabled persons, which is nearly one eighth of total disabled population of the world. Almost all problems in India are of a colossal magnitude. The financial resources available are meagre. We have a rural based society with 5,65,000 villages. The majority of Institutions and Rehabilitation Centres

are situated in the cities and only a handful of them are in the rural areas. Consequently the majority of the disabled in the villages are left to the mercy of the cruel fate depending on family or public charity for bare existence.

The disabled in developed or developing nations either of rural areas or of the cities, from good social and cultural environs or from the backward society are in no case less than normal humans beings. They may have some disability, deformity, deficiency but they do possess some talents, abilities and capabilities which are sufficient to prove their worth for the society and nation. In this paper I have not only undertaken those persons of the society who are labeled as disabled but also I have tried to show the impact of a sick society, poor environment and poverty striken region which, to a great extent, contributes to the impairment of many psychological characteristics and growth of such factors.

The cultural and group acceptance given to an individual is usually due to his physical, mental and other positive qualities. Persons with deficiencies and disabilities are prevented both socially and psychologically from participating in important activities on the basis of equality with normal individuals. This negligence, due to any number of reasons, not only effects the adjustment of such children throughout their lives but also hampers proper mental growth and personality development. Their disabilities always interfere in their interactions with others which may lead to passive participations in different social activities. The seriousness of the effects of disability are usually determined by how other people treat them, which often becomes an embarassing factor in the lives of the disabled. These disorders, therefore, lead to maladjustment and might also interfere in their overall development. The normal children, on the other hand, grow in the interlinked environs of home, school and community which help in their multifold developments. They have a place of their own in the intricate yet interesting matrix of familial and social relationships. For a handicapped child growing in the institution, family, or in the midst of many other children similarly stung by hydraheaded scourage of deprivation, they fail to have equal participation in day-to-day social activities. A child in such an atmosphere is bereft of those multiple relationships which a normal child in a family finds himself to be part of.

As per national policy on children 'the nation's children, the citizens of tomorrow, are supremely important assets who need to be provided equal opportunities to grow up to become robust citizens, physically fit, mentally alert, and morally healthy, endowed with skills and motivations needed by society.' Besides this, psychological growth of the children is also equally important for the whole life. In the case of handicapped too it is felt that they possess no less qualities and abilities to meet the worldly challenges in order to make their proper adjustment. Hence it is most important to identify *the strong and positive points* of them. Such knowledge about the hidden abilities and latent talents of a vast population will help the Government in formulating policies to rehabilitate them properly. This will also provide them proper and equal opportunities to prove their own worth and take part in the national affairs.

Aware of the debilitating impact of deprivations and handicaps Ministry of Social Welfare of the Government of India, has started thinking about proper rehabilitation of such individuals. They are yet far from reaching the goal. However, this 'global attempt' to rescue the handicapped properly may be of some use to this neglected and unidentified population. This active participation of academicians, professionals and others to identify their talent, recognise their worth and rehabilitate them will be an asset in this direction.

Research, although very rare and scanty relating to handicapped, has revealed that this neglected minority of the society possesses no less talent and abilities than the vast majority. Inspite of the fact that they possess more or less similar abilities, this population is faced with a number of problems, such as adjustment etc. in real life though the physically disabled are not fundamentally different from the normals. A handicap, severe or mild, is itself sufficient to arrest the normal development of the individual and to cause maladjustment and personality disorder (Kammerer, 1940). Subsequent studies on this population also showed that handicap causes a number of problems. Saxer (1958) reported that the emotional difficulties faced by the crippled, such as hostile withdrawal, sense of insecurity, lack of self confidence, extreme timidity, and passiveness were due to his unfortunate experience with siblings and parents. nI contrast, emotional difficulties did not appear when the parents truely loved their handicapped children. Similarly, Macgreor

(1951) found that the deformity not only places an individual at social and economic disadvantages but also plays a powerful role in determining the attitudes of the handicapped persons towards himself and influencing thereby his mental health. Custworth (1950), too, opined that "deformity makes the child apparently erratic, inconsistant and difficult, his social world tend to approve, develop and exploit his compulsive compensations and at the same time, to deplore and be baffled by his hysterical responses". Husain (1975) also found that normals scored better than handicapped ones on a number of factors of CPQ test. They were found to be more outgoing, participating and happy go lucky as compared to handicapped children. A few studies on the other hand, revealed that handicap is not an important factor influencing adjustment and growth of the individuals. According to Allen and Pearson, being disabled is not the sole cause of maladjustment, rather it seems to be dependent upon the number and severity of the problems with which the crippled is confronted. Some investigators found no real difference between the adjustment of the physically handicapped and normal children (Mussen & Newman, 1958). Scott (1971) reported that the blind handicapped behaved very much like the adults. Similarly they appear to be more concerned with maintaining their existing ego-structure than with adjusting to new social situations (Smoke et al: 195.). Fieldings' women disabled subjects demonstrated that acceptance of the disabled was positively correlated with general adjustment. Wenar (1956) infered that the handicapped child does not have the type of self control which enabled him to hold negative feelings in check, and function more objective and realistic basis. Kalyani Deshmukh (1980) also found institutionalized children inferior than normal children on a number of personality tests.

Besides personality and adjustment studies a few researches have also highlighted the mental capabilities i.e., intellectual and creative talents, of the handicapped. As regards their intellectual abilities these studies suggest that they possess average intelligence or atleast they are normally distributed (Hays, 1941; Fernald and Arlit: 1925; Mackie, 1945, and Russel 1952). Burnham (1872) may very well be cited in connection with the creative potential of the handicapped children "all children unless they are idiots, have productive, creative imaginations in some

measure". This was supported by the studies of Husain and Hasnain (1981). Tisdal et al (1967) found that sighted and blind children did not differ in their ability to think divergently. Katsonis (1971), failed to discriminate handicapped from normals in creativity test performance at the higher stage. The blind subjects of Torrance (1973), on the other hand, were found to be more creative than normals. Husain (1975) also found normals and handicapped equally creative on all factors of creativity test measures. Thus it may be said that elements of divergent thinking are found in every individual which might manifest itself as soon as suitable environment is provided (Lowenfeld, 1952, Guilford and Christenson, 1953, and Husain and Sahay, 1981).

The special kinds of subjects, i.e.; orthopedically handicapped, so far subjected to investigations and studies, have not been tested much with regard to achievement motivation. Conner, Rusalen and Cruickshank (1971) observed in their review assessment of literature on factors influencing the development of crippled children, "relatively little is known about the effects of degree and duration of disability, the age of onset, the family and home situation and the socio-economic status on the development of the crippled children". Jones (1974) pointed out that the studies of orthopedically disabled children's achievement and interpersonal relationships are rare. However, he concluded that impaired mobility and physical deficiency didn't influence significantly orthopedically handicapped children's school achievement or teachers rated interpersonal relations. The author, though on a limited sample, found that the performance of normals was better than the handicapped. It was interpretted that the poor performance of the crippled might be due to lack of concentration in the class room and also frustration and maladjustment caused due to 'unwell treatment' by teachers, class mates and peer group.

Husain and Sharma (1982) found that mentally retarded children showed a distinct improvement in their creativity scores after certain amount of training provided to them during a summer course programme.

Blindness arouses a more emotional reaction as compared to most other handicaps. The reaction of members of society to blindness vary. While some are uncomfortable in the company of blind and withdraw, others e.g. family members,

are extremely considerate and even become overprotective. There is yet a section which is ashamed of blind people and view blindness as a punishment.

Blind people can make effective adjustment with their environment provided the environment is conducive to their living. However, blinds when brought to a new group, say from family to residential school, loose contact with family and fail to make normal friendships in their community resulting in their growing as a social misfit.

It has been reported that blind children behave very much like adults (Scott, 1971). This is so because in the absence of vision they learn about the world mostly through adults.

Blind people are frequently disturbed by a fear of being observed by others. This is because it gives a feeling to them that something is done to them which they can not do to others.

The development of self in blind people is not similar to those having normal vision. While the sighted child knows that non-self is vaster and more complex than self, the blind child's direct experience is very limited. He fails to put himself into the position of another person and evaluates himself from that point of view. According to Cutsworth (1950) the problem of ego-development in blind people has a dual pattern. Firstly, when he develops compensation reaction to show that inadequacy does not exist in him, he grows along the line of compulsive personality. Secondly, he develops a false sense of security by failing to meet life aggressively and it results in hysterical responses which only add conviction to his feeling of inadequacy. "This dual pattern", writes Cutsworth, "makes the child apparently erratic, inconsistant, and difficult. His social world tends to approve, develop and exploit his compulsive compensations and at the same time to deplore and be baffled by his hysterical responses" (p.176).

Problems of mobility, fear of being watched and feeling of inadquacy are some of the main factors which resist the blind to increase their social responsibilities and relationships. Those blind individuals who are most successful are those who have not been directed by social-agencies, who mature emotionally as they advance vocationally. It would be interesting to find out how such people actualize in their life.

Sensory basis of language for the blind person and the sighted is different, and to that extent the common ground of shared meaning between them is limited. It is observed that blind children have a tendency to derive stimulation from words independent of their meaning. In training blind people, adults believe that sound, and not touch, is the dominant sense modality for them. We all know that our language is quite barren without visual imagery and there is hardly anything which could be conveyed in terms of tactile and kinesthetic experiences. Moreover, blind people do not have verbal realism like those of sighted people. For example he does not really know what a red or green colour is.

Training in matters of sex is another problem which merits attention. It is a very difficult task to teach a blind child as to what his sex organs can do, how to cover them and how to interact with a female. In a conservative society like ours, it is much more complicated to handle this task than elsewhere. Accordingly blind people have peculiar notions about sex and it is not surprising to come across cases of diffused and chaotic sex behaviour in them.

Klapp (1975) suggested that very short movements could be programmed and executed without feedback control. Because it has been reported that short targets are overshot and long targets are undershot (Hermalin & O'Connor ; 1975 ; Stelmach and Wilson, 1970). This difference may be attributed to programming and feedback in the execution of a response. In a recent study Kool (1980) reported that sighted subjects programme their movements for short targets by deriving support from their visual reference system. On the other hand, in the absence of any visual reference system, blind subjects depend upon their memory for movement alone and this is susceptible to decay at delayed recall intervals. Therefore it was not surprising in Kool's study that the difference between sighted and blind groups was highest at the 90-sec. interval. Recall of distance cue, one in which a movement of the same extent as on the standard trials but the starting point is somewhere midway, showed that the blind subjects performed better than sighted subjects on long targets of distance cue, while sighted subjects were superior to blind on the location cue. This clearly shows that, if long movements operate under feedback control the superior performance of the blind group is obviously due to

their greater dependence on and use of kinesthetic information. Role of response biasing, preselection and proactive inhibition have also been studied (Kool and Singh, 1979, 1980a, 1980b) in this connection.

Besides the above studies on movements of blind people, a number of studies on their tactual memory have also been conducted in the laboratories. We all know that what vision does to sighted people, touch does to blind people. Therefore, it is essential to understand the cognitive potential of the sense of touch as the blind child learns the crucial operation of analysis and synthesis of spatio-temporal relations even though loss of vision makes it more difficult. Braille reading alone is a clear example of how blind people struggle to make their effective adjustment with the use of the sense of touch.

In the past two decades a lot of work on tactile memory store has been conducted (Atteneave and Benson, 1969 ; Gilson and Baddeley, 1969, Sullivan and Turvey, 1972). Its applications on memory of blind people have also been reported (Bliss, 1966; Jones, 1975; Millar, 1974, 1976, 1977; Hermalin and O'Connor, 1978). In the first place, experiments conducted in the laboratory dealt with attention demanding and modality specific distractors on tactual short terms retention (Kool and Rana, 1979a, 1979b). It was found that certain types of distractors place greater attentional demands, and tactile retention is affected differently in the two groups, namely blind and sighted. For example, on the verbal distractor tasks the blind subjects not only took less time than the sighted, but also showed better recall accuracy at short recall intervals. On the other hand, their performance deteriorated far below the sighted group under sensitive movement distractor condition.

Besides the studies of the problems of the capabilities and talents of this population, literature also shows evidence of the impact of social and environmental forces upon a number of psychological characteristics and their impairments. Environment, cultural deprivation and povery are the principal agents which lead to different kinds of impairments and finally disability in any form.

From the days of Itard till now, the role of environs on intellectual and social competance has been realised widely. For quite sometime researchers have associated them-

selves with the problems of the disadvantaged people. The disadvantage and deprivation affect their number of mental and personality characteristics. Often the disadvantages of the rural child when compared with the urban poor seem to be insurmountable. The need for an enriched environment which can be stimulating for the children was also highlighted by Shanmugam (1978). Many other researchers also felt the need for an stimulating environment which can compensate the other disadvantages of the children (Hasnain and Husain, 1983, Gokulnathan, and Mehta, 1972, Rath, 1972, 1974, Sinha, 1977 etc.).

The quality of household environment as well as parental level of aspirations and motivation are the pertinent factors influencing a child's development. Richardson (1972) spoke of ecological variables such as mother's intellectual capacity, education and other characteristics also have some impact on child's growth. Richardson's concept of ecology was further elaborated in terms of physical and surrounding layers by Bronfenbrenner (1974, 1977). Social roles, family relationships, types of neighbour and peer group relationships and school are the important factors which require study.

Cultural deprivation has also been talked much in place of unstimulating environs, poverty, ecological setting etc. Cultural deprivation and poverty which have debilitating effect on the human development are also called low socio-economic status (Shanmugam, 1957, 1976). The western concept of cultural deprivation is different from that of Indian point of view. The former concept includes mostly low socio-economic group where in India it is both in terms of economy and social context. Besides many other things caste, religion, community and ecological settings also contribute to cultutal deprivation. Sen and Sen (1982) emphasised overcrowding as physical deprivation for a child after first year of age as compared to the culturally privileged child. A child gets frustration from the behaviour of the adults who find difficulties in many ways in a crowded family (Lewis, 1961). In a crowded atmosphere a child's activities are very much restricted and he gets very little stimulation from the adults who are poor models due to a number of limitations. In such situations the child finds himself in a typical position where he is supposed to be silent. obedient, and follower of the "models". This leads them to further frustration even in the schools. They show poor

performance, lack of interest in studies and deviance from the norms of the school. The above quoted facts were not found true at the later stage of life. The findings of Husain and Sarup (1979) and Husain and Jehan (1980) showed the adolescents of 11-14 years from deprived culture had significantly higher level of intelligence, creativity and achievement motivation as compared to their privileged counterparts.

Due to a very complicated nature of the Indian society it seems impossible to get rid of a number of social *evils* which the country is facing from an undated period. The problems of poverty, caste, regional, lingual and community prejudices and discrimination, poor civic condition, poor transport system, inadequate health services, inferior and sub-standard education etc. are in fact an unending menace to the growth of the people and the development of the nation as well. A planned and gradual attempt to eradicate such evils is most needed which might be possible to develop the right perspective.

The scope of preventive measure is still far from the reach of common men due to paucity of resources such as techical personnel, material, finances and the cooperation from the Government. The last few years however, have witnessed certain rays of hope as the Government has shown its interest in the upliftment of those who are deprived, handicapped and destitutes. This requires multisided help from the Government at the centre and states, local bodies and voluntary organisation for the rescue of the deprived and handicapped population.

Lastly, poverty, a phenomenon of multiple determination has been widely seen as affecting the intellectual and emotional aspects of the child. Poverty encourages the arrest of interest of the children in their school work and ultimately leads to delinquency etc. Poverty is one of the significant barriers which blocks the proper growth of psychological attributes. As discussed in the preceding sections an other important factor lies in the properties of the environment which plays a vital role. Barker (1970) emphasised the importance of the environment which underlie the differentials observed in the behavioural and general development of individuals. It has been widely recognised that the poverty-ecology combine affects the cognitive and many other psychological characteristics. Moreover, creativity, intelligence and achievement motivation have

been found to be influenced by environmental conditions. The impact of free home environment and culture is noticed upon creativity growth. A free culture with no strict norms promote creativity development (Straus and Straus, 1968; Husain and Sahay, 1981, Husain and Hussain, 1975, and Torrance, 1967). Northway (1956), Raina (1969), and Torrance and Gowan (1970) also reported that creativity is positively related to socio-economic conditions. Similarly development of intelligence like other cognitive factors, very much depends upon favourable environmental conditions (Morgan and King. 1974). Whiteman and Deutsch (1968), in their study found that more disadvantaged groups showed a decreasing trend in IQ with age. Das et al. (1970) observed that on intelligence test, poor Harijan children scored significantly lower than caste Brahmins. Lacy's (1971) study, too, showed high intelligence among high strata children. As regards Achievement Motivation a few studies showed that socio-economic conditions have positive bearing upon its development. Rath (1972, 1974) reported high level of aspirations for income, occupation and education for higer caste than poor tribal children. Pettingrews' (1964) Negroe subjects showed less need for achievement. Maclelland (1961) emphasised low need for achievement for Negroes from LSE strata. Gokulnathan and Mehta (1972) found that the urban non-tribals of high socio-economic strata had greater need for achievement than middle and lower counterparts. Atkinson (1964) found that the poor tend to lack in achievement motivation. Irwin Katz (1970) had also similar results. His poor subjects disliked self criticism and were less favourable to their self evaluation than well to do students.

Whatever the facts may be behind the problems of handicapped the fact is that they need an all round support and attention and recognition. I am sure the physical and psychological adjustment of theer psons with some disabilities, if provided the opportunities of equal participation in society's activities, will be smooth, positive and contributing. This can never be achieved by any legislation or enactment. This is the responsibility of the members and society to look them up, introspect one's own conscience, and give rise to conscious feelings of recognizing, helping and accepting the recognition of this population, who are full

of potentials and capabilities to contribute equally as others are doing. A mere conscious raising and verbal assurance can't be of any help until and unless we come with certain concrete programmes for their upliftment in the form of stopping further disabilities, finding the ways and the measures for the prevention of disability and finally rehabilitating them through proper training, vocationalization and helping them to realize population have also the rights to the human dignity and to enjoy a decent life. They should be provided proper medical, psychological and functional treatments. They must be given the chance of their own economic and social security as well as psychological equilibrium. They must be regarded and protected against exploitation and discrimination either in the family or in the society and environment. The disables are also dignified human beings who should have recognition regardless of race, colour, sex, religion and social origin.

Finally we have to be very much conscious about the types of disability and proper training with regard to those skills, efficiencies and aptitudes should be provided. The age old saying that success has its own psychology may very well be true with them if they find recognition, acceptance and opportunities to grow and contribute. For all this we need the kind of training programmes, education and vocationalization which will best suit their potentials.

We should make a collective effort to find ways to prevent the incidence of disability. The Government also needs to formulate policies of action in providing better services for both prevention and rehabilitation for the disabled in future. We as professionals have the responsibility of ensuring this policy being carried out and in providing a better understanding of the disabled so that these services may be more and more effective.

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Section II

Physically Disabled : Their Abilities and Disabilities

Introduction

A vast majority of disabled in our country belongs to the low income group who are usually termed as socially and economically deprived. Another category of individuals whom nature has denied the precious gift of vision or a limb or any other function are called handicapped. Such people are always discriminated in a number of ways due to their limitations. As a matter of fact none in the world is totally able or disabled. There is no clear cut demarcation between the 'able bodied' and the 'disabled'. As the outset of the term disabled suggests a state of helplessness; some thing which falls short of the norm or standard, viz. physical fitness.

Generally the term '*disabled*' or *physically handicapped* are used in an identical sense. The expert interpretation of the term is impairment (Sussman, 1977). The handicapped person or a person with some impairments should not be called a disabled person but a person with disability, as he has a large amount of potential abilities waiting to be developed and utilised. The strong and positive points of such people are required to be exploited for the good of the nation as well as their own. Such people should be encouraged to identify their own problems, realise their own worth and potentialities.

This section of the book has tried to explore the abilities and potentialities a handicapped individual possesses. In the first paper Punit Kapoor and Anima Sen have examined two kinds of blind, i.e. congenitally and adventitiously, and their sighted peers with regard to psychological variables such as personality and cognition. The results of the study showed no significant difference between the two groups on personality scores, i.e. Personal Perceptual Rigidity, Social Responsibility and Emotional Stability. However, the sighted group fared better than the blind and the congenitally blind fared distinctly better than the adventitiously blind on Forward Digit Scores and Backward Digit Scores. Kapoor and Sen have also

made attempts to establish relationships among various factors which showed no encouraging trend in a number of factors.

With three groups of children, i.e. Parentally Deprived, Physically Handicapped and Normal, K.N. Sharma and Dhanesh Khandelwal have studied Divergent Productions using Sharma's Battery of Divergent Thinking Tests.

The results of the study disclose that the parentally deprived had an edge over the other two groups on fluency and non-verbal elaboration scores as a matter of increased maturity. The three groups showed a unique trend of scores on different flexibility tests. However, all the three groups showed similarity on originality scores as not being affected by their respective backgrounds.

In his study M.G. Husain examines the divergent thinking abilities, academic achievement and personality factors of orthopedically handicapped and normal children. The results with two-fold analysis, correlational and comparative, were quite interesting. The two groups showed no difference on creativity scores but the normals fared better on achievement scores. On personality factors the two groups showed significantly reverse trend of scores on a number of factors measured by Child Personality Questionnaire. The interrelationships among various scores had quite different trends.

The paper by N. Hasnain and K.K. Joshi compares the lame boys with normal ones on some psychological factors. It was highlighted that the handicapped and normals showed no difference on anxiety scores. The study also discloses interesting facts as the normals were found to be more submissive and self disclosee whereas the lames were found more ascending.

Comparative Study of the Congenitally and Adventitiously Blind with their Sighted Peers on some Psychologcal Variables

PUNIT KAPOOR AND ANIMA SEN

Introduction

It is mainly through the visual modality that we receive accurate and gestalt impressions or our environment which assist us in orienting ourselves to the environment. As noted by Father Caroll (1961) loss of vision induces a variety of adjustment problems and personality deterrants. Baker (1954) also pointed out that blindness in an individual exerts a pro-found effect on his psyche.

Human beings differ in their personalities due to their interactions with different social environs. Because of their different experiences, the programming of the Central Nervous System is unique for each individual. It has been held that blind children show peculiar mannerisms after termed as 'blind-isms' which arouse negative feelings in the sighted. This is mainly a social stigma and recent research by National Institute for Visually Handicapped demolished the belief that majority of repetitive movements are linked with blindness (Advani 1982). Such stigma, however impedes social acceptance and integration of the blind. Due to the beliefs and prejudices held about blindness the blind are subjected to a different social environ-ment which is likely to be reflected in their personality. The blind person is dependent on the sighted for a number of infor-mations in day-to-day living. By nature of his dependency he develops the habit of subordination in his relations. He is deprived of various alternatives available to sighted in subordi-nate roles, and thus resorts to compliance (Scott 1976). The same induces a guilty feeling in the sighted while interacting with the blind who therefore try and avoid such exposures to guilt widening the gap between the blind and sighted. Also,

there are behavioural aspects which can be maintained only through visual feedback, lack of which restricts the range of behaviour. The sensory and motor limitations have a far reaching implication for perception and cognition, for example, Brown (1939) found a greater neurotic tendency in the blind. Studies by Hubbard (1935), Hastings (1947) and Malhotra (1979) indicated that the blind were more withdrawn and maladjusted than the sighted.

Age at which loss of vision sets in has a considerable effect on the mobility, educability and personality of the persons so affected. There is a consensus amongst those working in the field of blindness that the dynamics of personality development and social functioning of a congenitally blind person are substantially different from those of someone who is adventitiously blind. When blindness is congenital, the external world is specified right from the beginning in terms of information contained in the non-visual stimulation and the Central Nervous System is programmed accordingly. Though information is reduced there is redundancy in the organisation of the energy to which human beings are sensitive. Thus a good deal of information can be acquired by interpreting stimuli not generally used, since vision forms a better clue.

When blindness sets in at a later stage, Nervous System must be reprogrammed, behavioural sequences depending on visual feedback must be discontinued and new behavioural sequences assembled and maintained. Robert (1975) discusses that congenital blindness does not preclude normal affect and ego development while adventitious blindness is related to disruption of ego functioning with severe affect manifestations. Cholden (1958) elucidates the reorganisational states of a person who loses his sight at a later age goes through. Since the sightless person's social position, body image, capacities, interests and aims are deeply affected, a lot of readjustment is necessary. Immediately after the onset of blindness, the adult individual goes into a state of immobility or shock which is followed by a state of depression akin to reacture depression. It is after this that acceptance of ones' blind state comes in which is the prerequisite of adjustment to blindness. Understanding of these stages of anxiety and depression accompanied with blindness is necessary for apt counselling and enabling better adjustment of the blind in society.

Though effect of blindness on personality is accepted it is not clear as to which aspects are facilitated or retarded by it. Scott (1976) has pointed out the need for a study of the differential impact of congenital and adventitious blindness on personality.

The present investigation thus aims to study the effect of congenital and adventitious blindness on some psychological variables, both personality and cognitive, vis a vis with their sighted peers.

Methodology

Sample : The study involves comparison among three groups, the Congenitally blind, the Adventitiously blind and the Sighted.

The blind subjects considered for the first two groups were from, Blind Relief Association, Andha Mahavidyalaya, Panchkuian Road, and Sewa Kutir in Kingsway Camp, all located in Delhi.

Male adults of the age between 16 to 26 years were included in the sample. Female sample was not taken because of lesser availability of blind girls in Delhi who could be properly matched on age and education. The study did not include partially sighted individuals.

Children who lost their vision earlier than 5 to 6 years of age rarely retained visual image of vocational value, (Deshmukh, 1978). Accordingly, in the present study, for the congenitally blind group, individuals who became blind at birth or before 3 years of age, were considered. In adventitiously blind group taken the minimum age at which sight loss occurred was demarcated as 7 years.

The congenitally blind group consisted of 20 subjects and the adventitiously blind group 17 subjects. Most of the subjects belonged to a low socio-economic status, and came from urban and sub-urban places around Delhi. The range of education was tenth standard up to postgraduation. Two research scholars were also present.

The sighted group subjects belonged to twelfth standard up to postgraduation level, and were from low socio-economic background to match with the low socio-economic status of the blind subjects. The sighted group consisted of 20 subjects.

Though an effort was made to match the sighted and the blind on education and socio-economic status, it was not easy because the age of non-sighted people belonging to this particular education level was higher than that of the sighted. This is mainly because of the concessions offered by the Government to the blind students to study till a late age. Also, sighted boys belonging to a low socio-economic status specially from villages go in for a vocation rather than advanced education as their blind peers in the institutions do. Description of the sample is given in Table 1.

TABLE 1

Description of the Sample

Group	*Sample Size*	*Age Mean in years*	*Age Range*	*Model Educational Level*	*Educational Level*
Congenitally Blind	20	22.5	16-26	B.A. IInd Yr.	10th-P.hd.
Adventitiously Blind	17	23	16-26	B.A. IInd Yr.	10th-P.hd.
Sighted	20	20	17-23	B.A. Ist Yr.	12th-M.A.
Total	57	21.8	16-26		10th-P.hd.

Tools and Techniques used

The study involved a comparison of three groups, the Congenitally blind, the Adventitiously blind and the Sighted on a few psychological variables, both personality and cognitive.

Variables under study for the personality factor were Behavioural Rigidity, Social Responsibility and Emotional Stability. Forward Digit Span (FDS) and Backward Digit Span (BDS) were also determined to assess the congnitive aspect. Behavioural Rigidity and Social Responsibility were measured by the questionnaire Test of Behavioural Rigidity (TBR) Emotional Stability was assessed through the Maudsley Personality Inventory (MPI).

Behavioural Rigidity can be defined as the ability of the individual to cope with the restraints bounding his life space. Schaie (1959) studied the empirical observations which can be subsumed under the heading of Behavioural Rigidity. He designed the Test of Behavioural Rigidity to measure the ability of the

individual to adjust the stress imposed upon him by constant environmental change. The TBR test he developed has three components : Motor Cognitive Rigidity, Personality, Perceptual Rigidity and Psychomotor Speech Rigidity.

Personality Perceptual Rigidity seeks to indicate the individuals' ability to adjust to new surrounding, and change in cognitive environmental patterns. It is a measure to perceive and adjust to new and unfamiliar patterns and interpersonal relationship which itself sums an important aspect of adjustment in society. Thus this variable was considered appropriate to indicate adjustment, and TBR is the only available test to measure it. It is applicable to all adults. Motor Cognitive Rigidity and Psychomotor Speed Rigidity tests could not be administered because these tests are not applicable to a blind population.

For Indian population it was necessary to translate the TBR questionnaire into Hindi. The translation was done with the help of professional translator. Care was taken that the meaning of the statements remained unchanged.

In the TBR test, 44 items from the Social Responsibility scale of Califonia Personality Inventory are used, and assessment of these separately indicates the Social Responsibility Score and thus has been used to measure and compare groups on Social Responsibility which was considered as available because of the hunch that greater adjustment would produce greater Responsibility.

Neuroticism and Extroversion scores are indicative of an individuals emotional stability since extreme of either causes instability in an individual which in turn hampers his adjustment within the society. The two variables were measured through Jalota and Kapoor's (1964) modification of Maudsley Personality Inventory.

In accordance with Jenson's level I and level II Theory of Intelligence (1975), the two levels can be measured through the forward and backward digit span respectively. This test was found suitable for a blind population as no visual feedback was required; it was simple and not time consuming. Hence FDS and BDS were used to give a clue to the persons' level of intelligence. Forward and backward digit span measure the

memory span and thus propose to measure the relationship of adjustment and intelligence in the blind.

Procedure

TBR questionnaire was administered first followed by the MPI questionnaire to individuals or groups of two to three individuals, when in small groups the blind indicated the answers by raising either one or two fingers. These questionnaires, after a gap of five to ten minutes were followed by the forward and backward digit span administered to each one separately, away from the listening ability of the other interviewees.

Results

The data collected were analysed to determine if the congenitally blind, adventitiously blind and sighted groups differed from each other. Due to the hunch that the congenitally and adventitiously blind groups collectively may differ from the sighted, the differences between the two blind groups, C.B. and A.B. together and the sighted were also computed.

Table 2 shows the Mean, Standard Deviation, Range, of various groups in M.D.I., in terms of Neuroticism and Extroversion scores.

TABLE 2

Mean, Range and Standard deviation of groups on Neuroticism and Extroversion

M.P.I. variables		*Groups*			
		C.B.	*A.B.*	*C.B.+A.B.*	*S.*
Neuroticism	Mean	21.7	24.64	23.05	25
	S.D.	8.09	9.41	8.84	11.61
	Range	6-34	2-36	2-36	2-44
Extroversion	Mean	26.8	22	26.59	24.50
	S.D.	6.66	8.67	6.12	12.02
	Range	9-36	11-33	9-36	7-38

This table shows that the emotional stability scores of the congenitally and adventitiously blind do not differ much and the two groups collectively taken also do not show much difference. In fact the sighted group shows a slightly lesser score on emotional stability than the blind. Analysis of variance was conducted and no significant differences were found.

The Mean, Standard Deviation, Range, of various groups on Personality Perceptual Rigidity and Social Responsibility Scores derived from the TBR questionnaire are shown in Table 3.

TABLE 3

Mean, Range and Standard Deviation of Groups on Personality Perceptual Rigidity and Social Responsibility

T.B.R. Variable		*Groups*			
		C.B	*A.B.*	*C.B.+A.B.*	*S*
P.P.R.	Mean	44.7	43.94	44.05	42.05
	S.D.	4.72	6.15	5.44	4.04
	Range	38-62	33-53	33-62	34-49
S.R.	Mean	25.5	27.05	26.21	25.50
	S.D.	2.75	5.20	4.15	4.78
	Range	20-32	11-36	11-36	15-34

TABLE 4(a)

Mean, Standard Deviation and Range of Groups on Forward and Backward Digit Span.

Variables		*Groups*			
		C.B.	*A.B.*	*C.B.+A.B.*	*S*
F.D.S.	Mean	5.2	4.64	4.97	5.85
	S.D.	1.04	1.13	1.13	1.11
	Range	4-7	3-6	3-8	4-8
B.D.S.	Mean	3.2	3.23	3.23	4.0
	S.D.	0.89	0.94	0.91	1.18
	Range	2-5	2-5	2-5	1-8

The scores of the three groups were very similar and analysis of variance did not show any significant differences.

Scores on FDS and BDS are analysed in Table 4.

The sighted fared better than the blind in both FDS and BDS. Congenitally blind fared distinctly better than the adventitiously blind on FDS, however, the difference is not significant but on BDS the two groups fared equally. Analysis of variance was carried out and significant difference was found between groups on FDS. *t*-test was conducted to find as to

TABLE 4(b)

Summary of Analysis of Variance of the three Groups

Variables	*Source of Variance*	*S.S.*	*d.f.*	*M.S.*	*F*	*P*
F.D.S.	Between groups	68.18	54	6.67	5.28	.01
	Within groups	13.33	2	1.26		
	Total	81.51	56			
B.D.S.	Between groups	78.81	54	3.72	2.55	NS
	Within groups	17.44	2	1.46		
	Total	86.24	56			

TABLE 4(c)

***t*-test for Significance of Difference between Groups**

Variables		*C.B. vs A.B.*	*C.B. vs S*	*A.B. vs S*	*C.B.+A.B. vs S*
F.D.S.	Mean Diff.	0.56	0.65	1.21	0.88
	t	1.68	1.76	3.26	2.82
	p	N.S.	<.05	<.01	<.01
B.D.S.	Mean Diff.	0.03	0.8	0.77	0.77
	t	0.49	1.88	1.77	2.33
	p	N.S.	<1.05	<.05	<.05

which two groups differ significantly. Differences in Adventitiously blind and Sighted, 3.255 (p. 01) in congenitally blind and sighted 1.76 (pc 05) and in total blind population and

sighted, 2.82 (p. 01) were found for FDS. For BDS the difference between Adventitiously blind and Sighted was 1.7738 (pc. 05), between C.B. and Sighted was 1.88 (pc. 05) between entire blind population and sighted was 2.326 (pc. 05).

To determine the relationship, if any, between the various variables, correlation coefficients were computed. A relationship between Social Responsibility and Personality Perceptual Rigidity had been anticipated, however, no such relationship was found. FDS and BDS were found to be significantly correlated, in Adventitiously blind group $r=0.74$, the two blind groups taken collectively, $r=0.45$ sighted $r=0.6408$ and the entire population $r=0.57$. In the C.B. group, however, the relationship was not significant ($r=0.20$).

Discussion

Present research has grown out of the lacuna felt in the sphere of a comparative study of the congenitally and adventitiously blind people.

It has been generally held that the blind are very resistant to change and hold rigid view points. It was felt that there was an element of obsessiveness in the blind about the concepts of right and wrong. Dash and Mohanty (1981) found that the blind children are more rule abiding than the sighted children. The present study, however, shows that there are no significant differences in the blind and sighted on Personality Perceptual Rigdity.

It is felt that the withdrawal tendencies in the blind are greater than in the sighted, making them more emotionally unstable. Brown's (1939) and Malhotra's (1979) studies ratify this view point. Cholden (1958), while discussing the effect of age of onset of blindness on personality, states that persons who lose sight later in life suffer greater disability. This would lead to the presumption that the blind are less emotionally stable than sighted and adventitiously blind less than the congenitally blind. The findings of this study are not concordant with these results.

Juuarma (1962) reviewed the studies on the effect of age of onset of blindness on various mental functions and found that there was a suggestion that success in memory tests is positively related to an early onset and through this to the duration of

blindness. In everyday life the blind have to rely on various memory functions to a considerably larger extent than the sighted. Hence at the outset of this study, there was a hunch that the blind would fare better on forward and backward digit span. The results of present study show that the sighted fare better than the blind on these functions. An explanation offered here is that practice on one memory function does not generalise all memory functions. Thus the memory functions more practised upon by the blind are better developed than other including the Numerical Recall. Hayes (1938) shows blind to be superior to sighted on short sequence and forward digits recall. This can be attributed to the practice of the blind in memorising phone numbers etc. However, the present study finds a better recall in the sighted on FDS and BDS.

Erikson points out that a child experiencing rejection cannot be expected to develop trust in his environment. The greater rejection a blind individual suffers from his sighted peers, parents and siblings, the more resentful and emotionally unstable he would be. Malhotra (1979) finds a greater resentment in the blind, and Cutsworth (1933) states that the blind would at heart, like to hit out at society. This resentment and emotional instability is likely to influence the social responsibility of the individual. In this study no difference in the social responsibility scale was found between the sighted and the blind and no significant relationship between emotional stability and social responsibility. Neurotic people were held to be more rigid in their views but the study failed to confirm this.

A significant correlation was found between FDS and BDS. Jenson in his level I, level II theory of intelligence postulated that FDS is an indication of level I and BDS of level II intelligence, level I referring to simple reproduction of information and BDS to transformation of information before reproduction.

It is possible that this study did not show any difference in emotional security of the blind and sighted because the blind subjects considered were from blind institutions. Institutionalisation, as pointed out by Cowen et al (1961) and Malhotra (1979) is an important factor enough stimulation affecting the results. The sheltered life of an institution makes the blind feel sheltered and secure. It is possible that the insecurity may deepen when they step out and face competition

with the sighted. Depending on their environmental feedback, the attitude of their peers towards them, the blind may develop either acceptance of themselves or higher neurotic tendencies and withdrawal. The sense of inferiority and resentment they develop due to the negative reaction of society may either call for overcompensation or a drift into insignificant life. That to nullify the effect of institutionalisation, it would be worthwhile to make a suggestion that blind subjects with a domestic background and who interact daily with their sighted family, should be considered.

A possible explanation can be offered as to why no significant difference was found between the congenitally and adventitiously blind individuals. In this study the subjects taken under the group 'adventitiously blind' were those who lost their sight at the age of 7 or above. Most of the subjects came from a rural background and thus belonged to a low social status.

Jean Piaget (1952) formulates that the 'formative stage' of development sets in at the age of 11-12. Sen in 1976 noted the relationship between cultural handicap and poor congnitive development, i.e., a low socio-economic class individual is generally more prone to stimulus deprivation resulting in development of intellectual incompetence. Thus one may conjecture that in low social class children the formative age may be much after 11-12 years of age. Children losing their sight between the age of 7-10, (majority of our adventitiously blind subjects) therefore may not understand the full implication of their visual handicap in the social matrix. By the time the realisation comes, they have adapted their sensory-motor functions to their different blind status. It is possible that differences in adjustment, and the difficulties, would be detected when younger visually disabled are compared to their sighted peer and these dissipate by adolescence, and therefore cannot be detected in older visually disabled people.

Thus the results of this study are a just a cautious conclusion, it does not preclude the possibility of differences existing in the personality factors of the three groups.

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Divergent Productions of Parentally deprived and Handicapped Children

K.N. SHARMA AND DHANESH KHANDELWAL

Introduction

Freud (1949) postulated that the childhood experiences of an individual affect his adult personality development. The type of childhood experiences would and direct human behaviours even at a later stage. Those experiences are received by him from the environment of culture that curb his mental health. He was also of the opinion that childhood traumatic experiences create the feeling of desperate helplessness in the child (Freud, 1936). That anxietyful state accelerates his actions and plays decisive role in the child's survival. This is the condition which impels the organism in many ways—either helpful or harmful for his psychological development. In case of the organism with somewhat stronger ego the anxiety is overcome through certain mechanisms, direct or indirect. Creative production is one. He channelizes his energies in socially useful and constructive productions. This notion continues to be followed even now. Schooler (1972) has clearly shown the adult psychological functioning in terms of early experiences. Some empirical studies of childhood deprivations have different type of stories to narrate. Zubek (1969) has shown close relationship between cognitive processes and sensory deprivations. Segall and others (1966) and Broota and Ganguli (1975) have stressed the cultural factors responsible for cognitive development. Deprivations have detrimental effects over development of verbal ability (Whiteman and Deutsch, 1968), classification (Longley, 1972), identification, categorization and intelligence (Tripathi and Misra, 1976), competence (Schooler, 1972), learning and conceptualization (Werner and Murlidharan, 1970). In these studies two points seem significant : one, that the types of deprivations vary over studies and the other that

the relationships between deprivations and abilities are of both types—positive with some factors while negative with others. Some factors accelerate cognitive processes while others retard. The cognitive processes can be shaped and reshaped according to the nature of deprivations. Scarlett's (1980) study over children's isolation indicates an effect over foster relations. Absence of father in the family in childhood primarily affects males than females in mental development, social responsiveness and preferences for novel stimuli (Podersen and others, 1979). Then a question may also arise if divergent production abilities of intellect are affected by parental deprivation.

Adler (1929) also postulated that the disabled with organ inferiority develop a superiority complex as a compensatory mechanism for their disablement. A stutterer becomes an orator, poor in academic achievements becomes leader in society, handicapped becomes musician, novelist, poet, literary laureat, scientist or the like. History also provides us with such examples, like those of Einstein, Demosthees, Demoulins, Beethoven, Robert Franz etc. Their creative power develops ; they develop self-esteem and strive for superiority ; or any form of unihibited aggression, activity, potency, power or trait may develop. In fact, they absorb the impact of inferiority of their body and environment. The empirical view as surveyed by Hardman and Drew (1977) on physically handicapped people indicated that body growth, intelligence, cerebral palsy, motor skills, heart problems and dental abnormalities are affected. Rider (1977) indicated that in 7-13 years physically handicapped children perceptions are affected by conservation. The handicapped are interfered with the exploration of the world, affecting their language, performance, cognitive development, interpersonal relations adversely (Wolfgart, 1975), developing behaviour disorders and retarding language development (Fraser and Campbell, 1978). A question may be raised now if divergent production abilities are affected by handicap or not.

The above two questions are a pointer to formulate the null hypothesis that there is no difference between divergent production abilities of the non-deprived, non-handicapped, parentally deprived and physically handicapped children. Parental deprivation provides psychological functioning in personality development, while physical handicap provides

psychosomatic functioning in personality development. Thus the hypothesis may be able to provide some empirical bases to Freudian and Adlerian hypotheses,

Method

Tool : The divergent production abilities were measured through Sharma's Battery of Divergent Thinking Abilities Tests. It measures :

(1) Word Fluency, (2) Expressional Fluency, (3) Associational Fluency, (4) Ideational Fluency, (5) Adaptive Flexibility, (6) Spontaneous Flexibility, (7) Originality, (8) Verbal Elaboration, and (9) Non-verbal Elaboration.

Sample : The sample included three independent groups : (1) Non-deprived non-handicapped school going children with both parents (mother and father) and without physical disabilities ; (2) Parentally deprived children—children deprived of parents and brought up and educated in foster homes ; and (3) Handicapped children—children with physical disabilities, i.e, polio, absence or damage of limbs, eye, ear, nose or other part of body or any such deformity.

The size of sample for each group has been shown in Table 1.

TABLE 1

Size of Sample in Each Group

Group	*Size of Sample*	*Mean age*
1. Non-deprived non-handicapped	60	13.26 Yrs.
2. Parentally deprived	40	12.37 Yrs.
3. Physically handicapped	30	16.33 Yrs

Statistical Analysis : Duncan's Range Test was used to find out the differentials of the divergent production abilities between the three groups.

Results

The mean values on different divergent production abilities of the three groups have been shown in Table 2.

Application of the Duncan's Range Test between the difference of the mean scores obtained by the Ss of the three groups on different divergent production abilities indicated the required Rp values as shown in table 3 for reaching the significance.

TABLE 2

Mean Scores of the Three Groups of Sample on Different Divergent Production Abilities

Abilities	*Non-deprived non-handicapped*	*Parentally deprived*	*Physically handicapped*
Word fluency	31.53	37.87	37.00
Ideational fluency	28.49	33.25	35.28
Associational fluency	42.41	50.42	41.60
Expressional fluency	7.18	9.10	6.77
Spontaneous flexibility	15.96	13.70	17.90
Adaptive flexibility	7.00	7.52	4.83
Originality	1.15	0.38	1.30
Non-verbal elaboration	10.48	18.85	14.73
Verbal elaboration	5.40	7.05	6.77

TABLE 3

DRT results of the Differentials Between non-deprived non-handicapped (NN), parentially deprived (PD) and physically handicapped (PH) children.

Divergent Production Ability		*Group Combination*					
		NN-PD		*NN-PH*		*PD-PH*	
		Mean Difference	*Rp*	*Mean Difference*	*Rp*	*Mean Difference*	*Rp*
1		2	3	4	5	6	7
Wor.	F1	5.47	7.13	6.34	8.13	0.87	8.03
			9.33		10.80		10.67
Ide.	F1	4.76	5.50	6.79	6.96	2.03	6.53
			7.28		9.11		8.65
Ass.	F1	8.01	8.78	0.81	10.54	8.82	11.07
			11.63		13.97		13.81

1	2	3	4	5	6	7
Exp. Fl	1.92*	1.67	0.41	2.01	2.33*	2.09
		2.22		2.67		2.74
Spo. Fx	2.26*	1.97	2.06	2.37	4.20**	2.47
		2.62		3.14		3.23
Ada Fx	0.52	1.16	2.17**	1.39	2.69**	1.45
		1.53		1.84		1.89
Ori.	0.77	0.88	0.15	1.06	0.92	1.10
		1.17		1.40		1.44
NV El	8.37**	3.20	4.25*	3.65	4.12*	3.61
		4.14		4.83		4.78
V El	1.65	1.86	1.37	2.13	0.28	2.10
		2.44		2.81		2.79

*Sig. on .05 level;

**Sig. on .01 level of conf.; Rp values of upper lines are the values of .05 level and those of lower ones of .01 level for each factor.

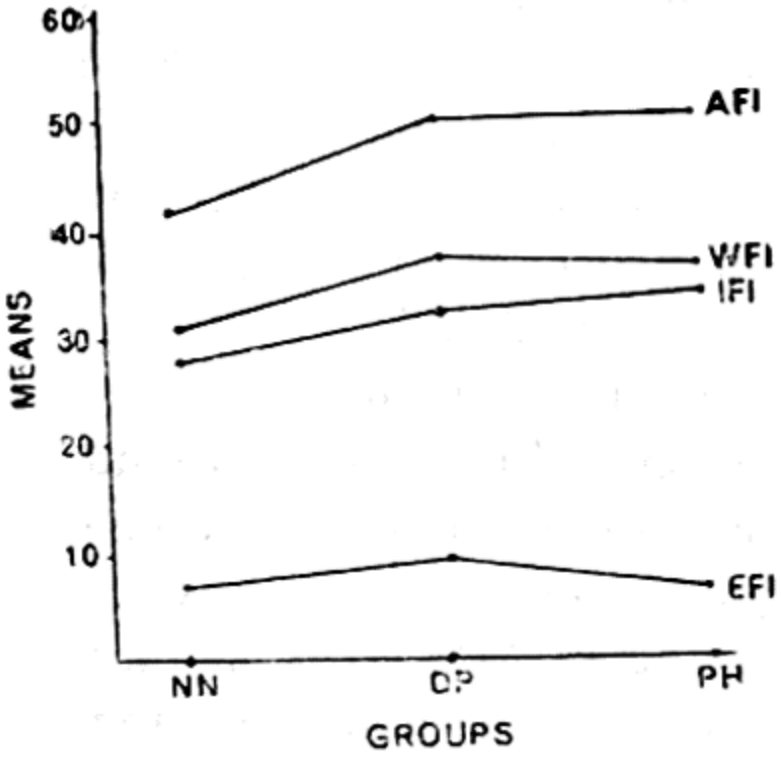
It is evident from the results of the table 3 that in spite of certain wide mean differences between three groups on three fluencies—word, ideational and associational, the differences could not gain significance as they could not exceed the Rp values calculated for each mean difference. It was only expressional fluency where the mean differences could clearly be observed significant between non-deprived non-handicapped group and parentally deprived group (NN PD at .05 level of conf.), and between parentally deprived and physically handicapped groups (PD PH at .05 level of conf.).

Interestingly enough on both flexibilities (spontaneous and adaptive) some mean differences obtained between the three groups have exceeded the required Rp values, thus reaching significance. On spontaneous flexibility the non-deprived non-handicapped group obtained significantly higher mean than the parentally deprived groups (sig. at .05 level). So did the physically handicapped group to a greater extent (PD PH at .01 level of conf.). In case of adaptive flexibility, the non-deprived non-handicapped and parentally deprived groups exceeded their means than that of the physically handicapped group at .01 level of significance $\left(\frac{NN}{PD}PH\right)$.

Originalities of all the three groups seemed to be equal because no mean difference could reach the reguired Rp values.

All the three groups were found to be significantly different

on non-verbal elaboration: NN PD (.01 level of conf.), NN PH (.05 level), PD PH (.05 level) while on verbal elaboration they



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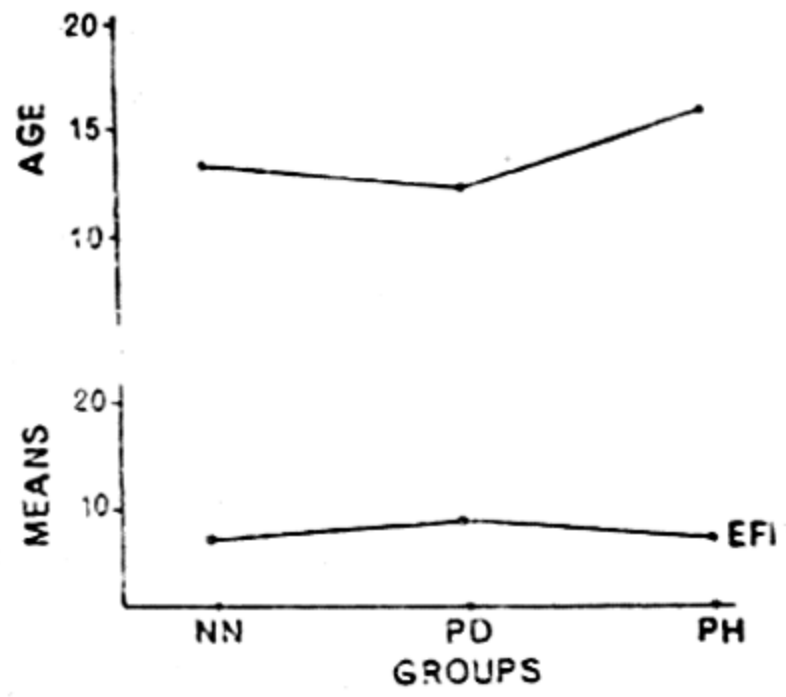

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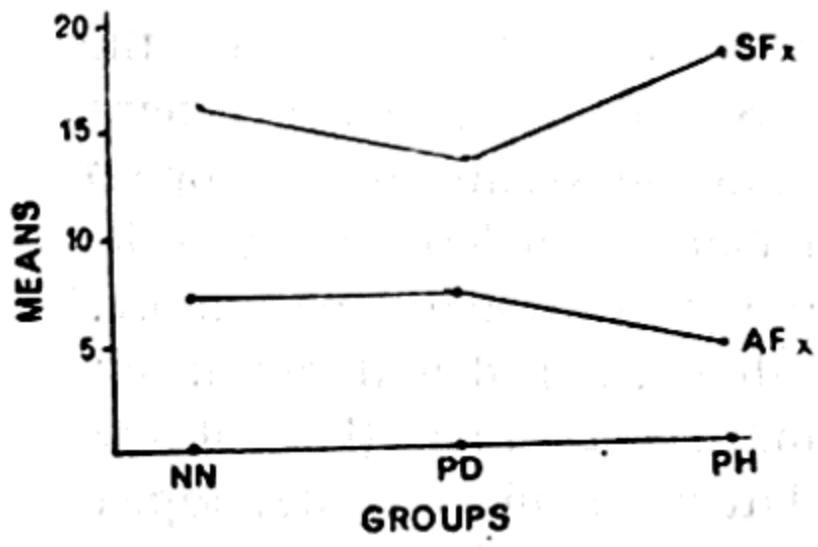

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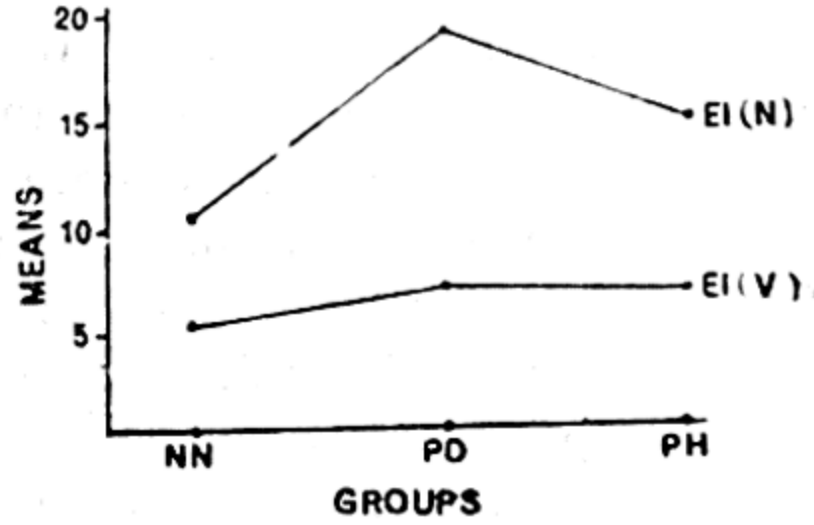

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were similar, the mean differences not touching the Rp values.

Thus the results indicated the following significant hierarchies:

Expressional Fluency:	PD | NN	PD | PH
Spontaneous Flexibility:	PH | NN	PH | PD
Adaptive Flexibility:	PD | PH	NN | PH
Elaboration (NV):	PD PH NN	

Discussions

The four fluencies used in the study, though factors of the same dimension of fluency indicated similar trends and linearity (see Fig. 1), yet some difference in their functions have been found in between the performances of the three groups of Ss. All the fluencies have the same semantic significance in verbality, but the first three (word, ideational and associational) which have the high score ranges than the fourth (expressional fluency), in-spite of wider gaps among their means remained similar among the three groups, and expressional fluency did not; rather found as distinctive fluency than others. Because the items of expressional fluency invovled tougher linguistic designs than those of word, ideational and associational fluencies, they could neither allow the Ss to respond so freely, on the one hand, nor the number of items was so big as for the first three fluencies, on the other. Moreover, the items of expressional fluency needed deeper linguistic function. In this case excellence of the parentally deprived Ss over the Ss of the other two groups (non-deprived non-handicapped and physically handicapped) may mean that parental deprivation increases independence in the children, struggle for survival and motivational aspect more. Though the Ss of non-deprived non-handicapped and physically handicapped groups had more mean ages than that of the parentally deprived Ss, yet the latter significantly developed expressional fluency; parental deprivation being boon for expressional fluency in spite of opposite age trends (Fig. 2). Parental deprivation thus increases maturity early, and develops fluent expressional productive capacities. However, Fraser and Campbell's (1978) hypothesis is not explained fully well by these results.

On both flexibilities (spontaneous and adaptive) the three groups of Ss spoke different stories. On spontaneous flexibility the parentally deprived group significantly remained lower than the other two groups, but on adaptive flexibility this function was taken over by the group of physically handicapped Ss (Fig. 3). Perhaps the non-unilaterality of results is representative of the differences between the two flexibilities or their specific variances, on one hand, and the sample specificity, on the other. Spontaneous flexibility represents more of a diverse attempt to the items in more unrestricted ways, while adaptive flexibility uses more of transformation in quality of products. The

parentally deprived Ss seemed to be more attemptive to the adaptive flexibility, a sign of more maturity than the other groups. They are apt to think diversely on ideas and problems-perhaps they are more independent workers than the Ss of physically handicapped group, who being unable to perform many physical tasks develop greater dependency, and thus low diverse thinkers, even significantly less than the non-deprived non-handicapped children in spite of their being of a higher age level.

The three groups performing similarly on originality scores is indicative that the preferences for novelty in the Ss of all the groups are not affected by the factors of their being of different groups. This idea also does not corroborate with that of Pedersen and others (1979). The Ss were, of course, instructed beforehand to give new, different, unique and useful ideas related to items of the test. This could motivate the Ss of all the groups, equally in producing novel ideas. This neither supports Adler's (1929) idea of organ inferiority as a factor of creative excellence nor does it support Freudian (1936) or Schooler's (1972) idea of childhood experiences directing production. The traumatic childhood experiences may affect social behaviours more than the productive ones.

Parental deprivation is not only boon for expressional fluency and adaptive flexibility but to non-verbal elaboration too. The significant excellence of the group of parentally deprived Ss than the other two groups is indicative of their exceedingly operative manually and mentally. This is perhaps because of their independence and early development of maturity due to increased responsibility. Of course the linearity of both elaborations (non-verbal and verbal) are quite similar (Fig. 4), but the significance could be achieved by some groups one over the other only in the non-verbal elaborations in the significant order of PD PH NN. This shows that Adler's (1929) contention has some meaning only in non-verbal elaborations. Non-verbal elaborations represent performance of extending details to figures. The Ss of parentally deprived group were able to produce more than those of the other two groups, i.e., they were most practical. It is because of their training, need and bent for performance. The non-deprived non-handicapped Ss were significantly least productive in detailing the figures. That group represented Ss from a Government School, where perhaps either the training was poor or their need was not so strong

as those of the other two groups. That group was taken as the controlled normative group for comparisons. Excellence of the physically handicapped group over the normative group shows some motivational aspects in the handicapped Ss, supporting Adlerian (1929) view to some extent in figural productions. The verbal elaborations as measured in the test were extensions and representations of the ideas subsumed in the detailed figures. The groups were ideationally equal in detailing. Such differences in results of the two elaborations clearly indicate their distinctive variances of figural and semantic natures.

Conclusions

Studies of Whiteman and Deutsch (1968), Longley (1972), Tripathi and Misra (1976), Schooler (1972), Wolfgart (1975), Rider (1977) and Werner and Murlidharan (1970) had shown that certain deprived conditions, like scarcity of food, money, physique etc. retard intellectual development, but this study indicates that parental deprivation accelerates some divergent production abilities, such as those of expressional fluency, adaptive flexibility and non-verbal elaboration while it retards spontaneous flexibility. Physical handicap retards expressional fluency, adaptive flexibility and non-verbal elaboration while it accelerates spontaneous flexibility.

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Divergent Thinking Abilities, Academic Achievement and Personality Factors of Orthopedically Handicapped and Normal Children

M.G. HUSAIN

Although much has been written regarding normals, the problem of handicapped children has always been ignored either knowingly or unknowingly. Besides studying normals from various aspects of their life they are being provided numerous opportunities to improve themselves and enable them to run comfortably in the competitive world. On the other hand, the children with some deficiencies have always been the subject of criticism and negligence. Not only that they find themselves the victim of criticisms putting them into embarrassed conditions they are also led to further deficiencies and maladjustment. Many people, social organizations and Government agencies talk more about their welfare and do little. The physical, mental or other disabilities of the handicapped due to which persons are generally perceived in their cultural group to have such qualities prevent them from participating in important activities on the basis of equality with individuals of their own age. This negligence due to one reason or the other affects the adjustment of such children throughout their lives. Their disabilities always interfere with their adjustment which leads to passive participation in different activities with their age-mates. The seriousness of the effects of disability is usually determined by how other people treat them which is often found embarrassing for the defectives. These disorders, therefore, lead to maladjustment or sublimation or compensation.

The normal children, on the other hand, grow in the interlinked environments of home, school and community. Each offers him a variety of experience and opportunities for many-sided development. They have a place of their own in the intri-

cate yet interesting matrix of familial and social relationships. For a handicapped child growing in the institution, family or in the midst of many other children similarly stung by hydra-headed scourage of deprivation the situation is different. They fail to have free-hand participation in day-to-day social activities. The institutions very often constitute the totality of a limited existence. Even the biggest and largest institutions can offer no more than an acutely circumscribed environment. A child in such an atmosphere is bereft of those multiple relationships which a child in a family finds himself to be a part of.

Aware of the debilitating impact of deprivations and handicaps the Government of India, Department of Social Welfare, started thinking about proper rehabilitation of such individuals. But very few practically effective steps have been taken by them. However, few welfare and rehabilitation centres have been established all over the country which too proved to be of no much use.

This study was conducted in the Department of Educational Psychology and Foundations of Education, NCERT, with the feeling that its result would provide some valuable information to the Government of India which wanted to abolish special schools for the handicapped and integrate them with normal children.

Researches, although very rare, in connection with handicapped, bring the facts into light that this neglected minority of the society possesses no less abilities than the vast majority of normals. As regards the intellectual abilities of the handicapped the studies suggest that they posses alteast average intelligence or even they are normally distributed (Hays, 1941; Fernal, and Arlett, 1925; Mackie, 1945; and Russell, 1952 etc.).

So far as the creative potential of the handicapped is concerned Burnham (1872) may well be quoted "all unless they are idiots, have productive, creative imaginations in some measures".

Tisdel et al (1967) found that blind and sighted children didn't differ in their ability to think divergently. Similarly Katsounis (1971) failed to discriminate deafs from normals in creativity test performance at the higher stage whereas blind subjects of Torrance et al (1973) were found to be more creative than the normals.

Rogers (1968) measured fluency and originality of disadvan-

taged children. He observed that "disadvantaged children can express themselves as originally and fluently as advanced pupil in visual areas". Torrance (1969), too, found disadvantaged either equal or even superior to similar advantaged groups in figural fluency and originality. Smith (1965), in a study of the relationship beween creativity and social class, compared scores of black subjects with those of white subjects. His findings revealed whites superior on most of the non-verbal factors. Hence it may be said that element of divergent thinking is found in every individual who might manifest itself as soon as suitable environment is provided (Lowenfeld, 1952 ; Guilford and Christensen, 1953 : and Hussian and Sahay, 1981).

The special kind of subjects, orthopedically handicapped, undertaken for this study have not been tested with regard to motivation. Conner, Rusalem and Cruikshank (1971) observed in their review and assessment of literature on factors influencing the development of crippled children "relatively little is known about the effects of the degree and duration of disability, the age of onset, the family and home situation and the socio-economic status on the development of crippled children". Jones (1974) pointed out that the studies of orthopedically disabled school children's achievement and interpersonal relationships are rare. He further observed that possible explanation for this avoid was due to great diversity among children and classifications make generalization quite unreliable. Such a view, notwithstanding, there are number of important questions about personality characteristics, degree of disability, ...particularly physical deficiency...and school achievement and about other correlates of orthopedically disabled school children's achievement and interpersonal relationship which need to be addressed.

As the degree of physical dependency decreases and mobility increases, the orthopedically disabled child becomes more internally controlled and better adjusted in his relationship with others (teachers and peers) and he achieves the higher level.

The converse, of course, is that with increased physical dependency and with decreased mobility the child becomes externally oriented in his relationship to his environment, impaired in relationship with significant others and achieves at lower level. Jones (1974) found in his study that impaired

mobility and physical dependency did not influence significantly orthopedically disabled children's school achievement or teacher rated interpersonal relations.

Physical deficiency and other handicaps make children internally controlled and better adjusted in their limitations. It is also evident from the literature that every individual in the society possesses more or less all the qualities. Like others, the orthopedically, orally and aurally handicapped children should have equal productive quality as compared to normals. They should also compete the normals with regard to school achievement.

It looks that all the children do possess somewhat the same abilities with the exception of individual differences. In some cases the orally and aurally handicapped superseded or equated the normal peers. But in the present set up of the society in India the handicapped are neglected. In the present study attempt has been made to see how do the orthopedically handicapped differ from normal children of the same background with regard to creative potential, school achievement and personality correlates.

Alike bright and gifted children who have more and more facilities to utilise their talents in the productive and constructive ways, the handicapped with superior qualities, if any, should also be provided similar facilities, to improve their qualities and grow as making useful contributions to our society and the nation. As evident from some of the available researches it seems that the handicapped children are either equal to the normals or superior in their performance levels. Although due to lack of studies in relation to handicapped children's different qualities no concrete hypothesis could be postulated. However, the following hypotheses were tested to arrive at some conclusive results :

Hypotheses

1. Do the orthopedically handicapped children differ from normal children with regard to creativity and achievement ?
2. Do the above factors correlate among themselves of both the groups ?

3. What are the personality correlates of the above factors, i.e. creativity and achievement.
4. Do they (two groups) show any difference on personality characteristics ?

Methods

The study was permitted to be conducted with a very limited scope as regards the selection of subjects and kinds of variables as well as the use of tools etc. However, attempts were made with necessary precautions to abide by the suggestions.

Sample : As the study involved selection of rare available subjects the size of the sample was raised only upto 25 in each group, i.e. orthopedically handicapped and normal children. The subjects were chosen from two hospitals of South Delhi—Safdarjung Hospital and A.I.I.M.S. The subjects were between the age group of 10 and 14 years. They were matched with regard to parental education, socio-economic status, age and intelligence. The matching was done according to the qualities and characteristics of the handicapped (one to one). Other criteria of different groups were determined as follows :

1. *Orthopedically handicapped* : The children suffering from either poliomaylities, or with limb problem or lames, either inborn or due to any disease or accident were taken from different hospitals for this study.
2. *Normals* : The children counterbalancing or matching the above group in respect of age, schooling, socio-economic status, culture and family background and also intelligence were taken for this group. Attempts were also made to pick the subjects up from the areas wherefrom the handicapped were taken.

Tools : A number of tests and inventories were used for this study.

Convergent Thinking Ability Test : Jalota's GMA-60 was applied to match the normals with orthopedically handicapped children on intelligence. Only subjects showing average intelligence were taken.

Divergent Thinking Ability Test : Indian adaptation of Wallach and Kogan's Creativity Instruments (Verbal) by Paramesh were administered to the subjects in order to measure divergent thinking abilities (Creativity).

Academic Achievement : Record of last school examination showed the academic achievement of the subjects. These marks were not necessarily the same for all the subjects hence standard score for each subjects' marks was obtained.

Familial Structure Scale : In order to obtain personal data of the subjects this scale was constructed by the author on lines of 'Biographical Inventory' by Anastasi and Schaefer.

C.P.Q. (14-Personality Factor): Indian adaptation of Cattel's C.P.Q. was used to measure 14 distinct dimensions of personality of the subjects. All the 14 factors—A, B, C, D, E, F, G, H, I, J, Q_1, Q_2, Q_3 and Q_4 give two dimensions, i.e. high and low, of personality.

Scoring of the Tests : Cattel's C.P.Q., Jalota's GMA-60 and Wallach and Kogan's Creativity Instruments were scored for personality , intelligence and creativity respectively. In order to bring symetry standard scores were obtained for school marks. Product moment coefficient of correlation was run to find out interrelationships among different scores of creativity, academic achievement and personality factors. *t*-Test was applied to find out differences between two groups on all the factors undertaken for the study.

Procedure : All the tests were administered to the subjects individually on different days. For handicapped subjects it was done in the two hospitals whereas the normals were given tests in their respective institutions. In both the cases the hospital authorities as well as school administration provided necessary facilities required by the investigator.

Results : The present study intended to investigate if there is any similarity or difference between two groups of subjects,

TABLE 1

Results showing interrelationships among Achievement, Number, Uniqueness and Composite Creativity (N.U.C.) scores of Group I (Normals)

	Achievement	*Number*	*Uniqueness*
Number	·33*		
Uniqueness	·001	·56**	
Composite Cr.	·29*	·98**	·67**

*Sig. at ·05 level, **Sig. at ·01 level

i.e. orthopedically handicapped and normals, on creative potential, academic achievement, and personality factors. It also aimed at investigating the inter-relationship among different factors of creativity (Number, Uniqueness and Composite Creativity), academic achievement and 14 factors of personality. The results are shown in following tables and figure.

Above results depict that all the creativity factors are highly interrelated. All but uniqueness score are also significantly correlated with achievement.

TABLE 2

Results showing interrelationship among Achievement (A), Number (N), Uniqueness (U), and Composite Creativity (C) scores of orthopedically handicapped children

	A	*N*	*U*
Number	·09		
Uniqueness	·13	·33*	
Composite Cr,	·12	·96**	·55**

*Sig. at ·05 level, **Sig. at .01 level

The above table shows that all factors of creativity are highly interrelated but none of them is related with achievement though *r*s are positive.

Discussions and Conclusion

The results of the present study very interestingly disclose the facts regarding two group of subjects. Subjects belonging to normal and handicapped groups were studied for the variables like academic achievement, creativity and its factors (N, U) as well as personality correlates (C.P.Q.).

Creativity scores of both the groups were found to be interrelated. But the achievement score of the handicapped group was unrelated to creativity scores whereas the same scores of normals were related with different creativity scores except uniqueness. The interrelationships among A, N, U, and C scores and 14 personality factors were not encouraging at all. However, the normals' scores on F, J, Q_2 and Q_3 factors were positively and significantly related with N, U, and C scores. No relationship was found between A and personality scores. The handicapped, on the other hand, showed

TABLE 3

Relationship among A, N, U and C with 14 factors of personality of normal subjects

	A	B	C	D	E	F	G	H	I	J	Q_1	Q_2	Q_3	Q_4
A	.03	.01	—.002	.05	.01	—.01	—.05	—.09	—.15	—.04	.04	.05	—.15	.0
N	.004	.028	—.36*	.06	.11	.30	.04	.33**	.01	.17	.06	.42	.09	.10
U	—.24	—.45*	—.51**	—.05	.34**	.02	—.15	.002	.30*	—.10	.09	.22	.08	.14
C	—.05	—.09	—.45*	.05	.06	.35*	—.03	—.25	.15	.01	.23	.03	.40	.12

*Sig. at .01 level, **Sig. at .05 level

As shown in the above table none of the personality factors is related to academic achievement of normal subjects. F, J, Q_2 and Q_3 factors of personality were positively related with N, U, C and factors B and C were negatively (significant) related with N, U, and C.

TABLE 4

Relationship among A, N, U, C and 14-personality factors of orthopedically handicapped subjects

	A	B	C	D	E	F	G	H	I	J	Q_1	Q_2	Q_3	Q_4
A	.05	—.02	—.006	.07	.03	—.01	—.09	—.07	—.10	—.04	.07	.09	—.10	.04
N	.05	—.04	.03	.004	.03	—.01	—.01	.03	.09	—.02	—.03	—.05	—.05	.10
U	.20	—.23	.04	—.02	—.04	—.09	—.01	.07	—.005	—.08	.06	.11	.13	.04
C	.02	.01	—.25	.03	.02	.25	.03	—.02	.15	.01	.26	.02	.40*	.09

*Sig. at .01 level

As depicted in the above table academic achievement was unrelated to all the factors of personality as well as creativity. Only Q_3 factor of personality was found to be significantly correlated with total creativity (C).

TABLE 5

Results obtained by *t*-test showing the significance of difference between two groups (normal and handicapped) on N, U, C and A scores.

	Achievement	*Number*	*Uniqueness*	*Composite Creativity*
Normals Mean	15.72	34.56	1.88	36.44
Critical Ratio	2.88*	1.62	.27	1.49
Handicapped Mean	14.24	30.08	1.78	31.80

Sig. at .01 level.

As revealed by the above table the two groups don't differ significantly on their creativity scores but the normals had an edge over their handicapped counterparts on achievement scores.

TABLE 6

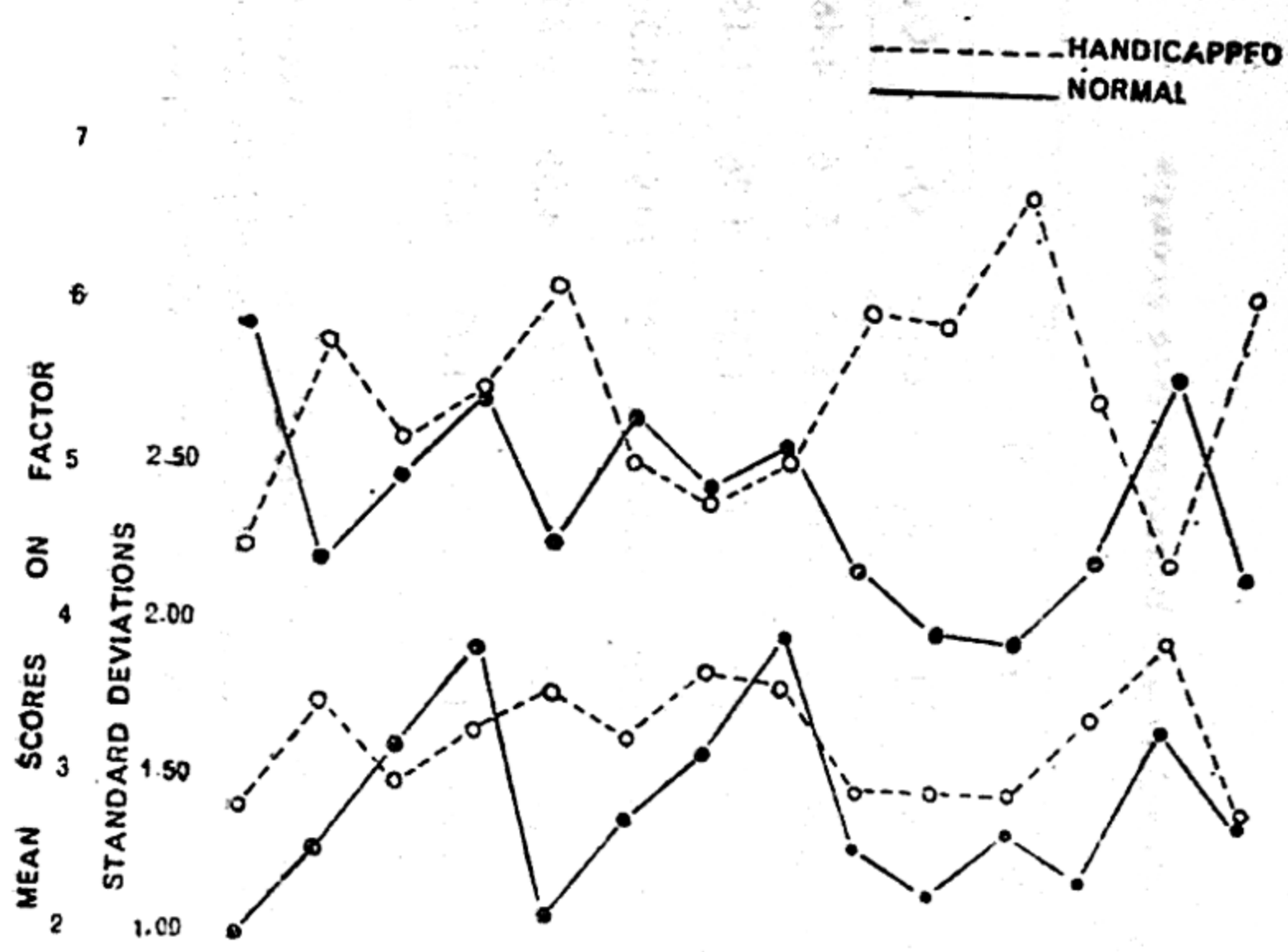
Results obtained by *t*-test showing the significance of difference between two groups on CPQ scores

		N		O	R	M	A	L	S			
	A	B	C	D	E	F	G	H	I	J	Q_1	Q_2	Q_3	Q_4
HANDICAPPED	M 5.88	4.40	4.92	5.48	4.64	5.40	4.96	5.20	4.48	4.08	4.00	4.32	5.36	4.48
	SD 1.01	1.29	1.63	1.96	1.11	1.41	1.62	2.02	1.33	1.19	1.41	1.25	1.76	1.45
	15.86*	14.37*	2.69**	.18	16.13*	2.82**	1.15	.55	17.05*	21.05*	29.38*	12.72*	10.99*	18.30*
	M 4.48	5.82	5.19	5.50	6.20	5.12	4.84	5.14	6.11	6.05	6.85	5.57	4.55	6.25
	SD 1.43	1.76	1.51	1.70	1.81	1.67	1.76	1.72	1.53	1.53	1.53	1.77	2.03	1.47

*Sig. at .01 level, **Sig. at .05 level

The results shown by the above table reveal that the two groups have differed significantly on all the factors except D, G, and H. The normal scored better on factors A, F, & Q_3 whereas the handicapped subjects scored higher on factors, B, C, E, I, J, Q_1, Q_2 and Q_4. This implies that the two groups develop two distinct types of personality characteristics due to one reason or the other.

Figure I



more or less similar trend showing indifferent results. Achievement scores were unrelated to personality factors. Moreover, their U scores bore significant and positive relationship with factors A, Q_1, Q_2 and Q_2. But Q_3 had significant positive relationship with composite creativity scores. No other correlation was found significant. However, both the groups showed somewhat insignificant positive and negative relationship with creativity.

The two groups when compared with one another showed significant difference only on achievement scores showing normals better. There was no difference on creativity scores and its factors. As regards the personality factors of the two groups they showed quite different trend of scores (Table 6 and Figure I). The normals were high on factors A, F, and Q_3 showing them more outgoing, as well as participating (A), happy go lucky and enjoying (F), and self controlled and also precise (Q_3) as compared to the handicapped. The handicapped showed higher scores on B (intelligent and abstract thinking), C (emo-

tionally stable, realistic) E (assertive, independent and dominant), I (tenderminded), J (internally restrained), Q_1 (depressive and apprehensive). Q_2 (self sufficient) and Q_4 (tense and overfrustrated factors of personality.

While comparing our findings with those of Katsounis (1971), Tisdel (1967), Cruikshank (1971) and Jones (1974) who found that the crippled or handicapped as well as disadvantaged children were no less than their normal counterparts on creativity test performance scores we find our results consistent with the above studies. However, there was slight mean difference between the two groups which were insignificant. The studies by Torrance et al. (1973), Torrance (1969) and Smith (1965) are contradicted here as they found their handicapped subjects (deaf and blind) performing better than the normal counterparts. However, on non-verbal factors, Smith's black subjects performed less than the white subjects.

The two groups showed different trends with regard to academic achievement as normals scored better than the handicapped. The achievement scores of normals was positively and significantly correlated with creativity scores which lacked in the case of handicapped. This might be due to their poor concentration in the class room as well as unwell treatment by teachers and class mates leading to frustration and maladjustment. There is no available study which can be compared with our results. However, the opinion of Jones that school achievement of orthopedically disabled child will be better due to their becoming more internally controlled and better adjusted is contradicted by our results. We see that our handicapped subjects showed an opposite trend.

While looking at Tables 3 and 4 we find that both the groups showed unrelatedeness with regard to achievement and creativity scores with peronality factors. However, some relationship has been found between these factors of both the groups. This has revealed that creativity bears relationship with factors A, F, Q_2 and Q_4 in the case of handicapped and F, J, Q_2 and Q_3 in the case of normals. Our results also showed that two groups differ distinctly on all but D, G, and H factors of personality as measured by C.P.Q. The normals scored higher on A, F, and Q_3 factors whereas the handicapped scored higher on all the remaining factors. There is no available study with regard

to personality correlates of handicapped subjects so it is difficult to discuss our findings in the light of earlier results.

The present study with its limited scope is able to disclose many interesting facts. Both normals and handicapped showed equal potentials with regard to creativity which confirm the views of Burnham that "all unless they are idiots, have productive, creative, imaginations in some measure" as well Husain and Sahay that "creativity, more or less found in everybody, is reflected at proper time and situation".

Academic achievement of normals might be high due to their proper schooling, parental background and attention paid to them by teachers and peers. As the handicapped fail to receive such treatment they are unable to show better performance due to frustrations.

The personality scores of the two groups revealed the fact that the normalcy as well as the handicap have both positive and negative bearing upon the growth of personality characteristics.

Lastly, we can say that creative potential is unaffected by physical handicaps and it may be increased among such population with various methods. Other factors, achievement and personality characteristics, are very much a matter of situational treatments given to the pupils. This study needs further elaboration with large number of sample to generalise or universalize the results.

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A Comparative Study of Some Psychological Factors of Lame and Normal Boys

N. HASNAIN AND K. K. JOSHI

Introduction

As early as in 1872 Burnham expressed his views regarding orthopedically handicapped that all unless they are idiots, have productive and creative imaginations in some measures. Baker (1944) found that average intelligence of crippled children was below normal ; but the variability was great, and some were of superior intelligence. Tayler (1969) has pointed out the general conclusions are that no physical condition except one that acts on the central nervous system itself has serious effects on intellectual efficiency, at least for limited periods of time, and that no developmental handicap except one that severely restricts the individual's contact with his environment and his mastery of language has a serious effect on his I. Q. The findings of researches on creativity of orthopedically handicapped are not in consonance (Rogers, 1968 ; Torrance, 1969 ; Katsounis, 1971 and Torrance *et. al.*, 1973).

Physical handicap putting the sufferers in disadvantageous positions surely influences their psychological development in an adverse direction. Often the physically handicapped child, though, is able to carry his reading and writing business at a normal rate, yet he is unable to participate in various co-curricular activities. As a result, his intelligence is not marred, but his social interaction surely shrinks, which influences different aspects of his personality in a negative way. Such a condition brings adjustment problems to disabled children. Moreover, the inability in participating various co-curricular activities also makes the physically handicapped child shy, anxious and submissive. The empirical studies on sensory disabled and normal subjects provide evidences to this

view. Gotzinger *et. al.* (1966) found that deaf adolescents manifested more aggressive, behavioural consistency, non-conformity, less cooperation and anxiety than normal subjects. Deaf and dumb children were found to be socially, educationally maladjusted and emotionally disturbed and unstable (Sood, 1972 and Sharma, 1977). Pintner *et. al.* (1941) did not find differences in ascendence-submission, introversion-extraversion and emotional behaviour of hard hearing and normal children. Sablok (1976) found that blinds were suffering from the feeling of inferiority. Bhargava and Lavania (1981) concluded on the basis of their studies that sensory disabled children were more reserved, emotionally unstable, obedient, shy, dependent, sentimental, secure and relaxed than their normal counterparts.

The situation becomes grave for lame child, because he is even unable to walk by the side of the children of his age-group. But as Jones (1974) pointed out that the studies of orthopedically disabled children's achievement and interpersonal relationships are rarely found.

The present study was, therefore, conducted with the aim to find out the differences in anxiety, ascendence-submission and self-disclosure of lame and normal boys. The following hypotheses were set for testing.

(i) The lame boys will significantly be more anxious than normal boys.

(ii) The lame boys will significantly be more submissive than normal boys.

(iii) The lame boys will significantly be lesser self-disclosees than normal boys.

Method

Sample. 10 lame students were taken on an availability basis from Educational Institutions of Pithoragarh city. The age-range of these subjects was 18 to 20 years and their mean age was 19.1. 10 normal students were randomly selected from the same Educational Institutions from where the lame students were taken. The age-range of normal students was also 18 to 20 years and their mean age was 18.9. The normal subjects were randomly selected from the same institutions, classes and sections from where lame students were taken. The cultural background of the subjects in the two groups were almost same.

Tools. The following tools were administered to the subjects for data collection.

(1) Sinha's 'comprehensive anxiety scale' was used to measure the comprehensive anxiety of the subjects. There are 90 items in this scale. The respondents respond in terms 'yes' or 'no'.

(2) Dwivedi's ascendence-submission scale' (Dwivedi, 1976) was used to measure the ascendence-submission tendency of the subjects. The scale consisted of 25 items. This is a five point scale.

(3) Sinha's 'self-disclosure inventory' (Sinha, 1977) was used for the measurement of self-disclosure of subjects. There are eight areas of self in this inventory. These are : money, personality, study, body, interests, feeling ideas, vocations and sex. There are 10 items in each area. The items in each area are responded with reference to six figures, namely ; mother, father, brother, sister, friend and teacher. This is a three point scale.

Results

Median test was applied and chi-square with correction (Garrett, 1969; pp. 265-270) was used to find out significant differences between the median anxiety scores of lame and normal subjects.

TABLE 1

Showing Common Median of anxiety scores, number of subjects falling in below and above median cells and the result of X^2c

Common Median=28.50				
Groups	Below median	Above median	X^2c*	Remarks
Lames	5	7	0.45	>.05
Normals	7	5		

*$X^2c = X^2$ with correction

Table 1 shows that chi-square value between median anxiety scores of lame and normal students is .45, which is not significant at any level of confidence.

TABLE 2

Showing Common Median of ascendence-submission scores, number of subjects falling in below and above median cells and result of X^2c

Common Median=90.50				
Groups	Below median	Above median	X^2c	Remarks
Lames	4	8	4.12	<.05
Normals	8	4		

A look over Table 2 shows that chi-square between the median ascendence-submission scores of lame and normal group is 4.12, which is significant at .05 level of significance.

TABLE 3

Showing Common Median of self-disclosure scores, number of subjects falling in below and above median cells and the result of X^2c

Common Median-460.00				
Groups	Below median	Above median	X^2c	Remarks
Lames	8	4	4.12	<.05
Normals	4	8		

Table 3 reveals that chi-square between the median self-disclosure scores of lame and normal boys is 4.12, which is significant at .05 level of significance.

Discussion

A look over Table 1 reveals that the value of chi-square between the median anxiety score of lame and normal boys is 0.45, which is insignificant at .05 level of significance. Thus, the first hypothesis that lame boys will significantly be more anxious than normal boys is refuted. It indicates that lameness perhaps did not bring anxiety to the sufferes.

Table 2 depicts that the chi-square between the median ascendence-submission scores of lame and normal boys is significant at .05 level of significance. The number of subjects in below median cell in case of lame subjects is 4 and in the same cell the number of normal subjects is 8. The number of

lame subjects in above median cell is 8 and that of normal subjects in the same cell is 4. Thus the lame subjects seem to be more ascendent than normal subjects. In other words, normal subjects are more submissive than lame subjects. Thus, the second hypothesis that lame boys will significantly be more submissive than normal subjects is rejected and results contrary to the hypothesis is obtained. In this way, because of inability to take part in some of the activities, the lame subjects seem to observe the general rule of becoming aggressive towards their environment to maintain a kind of balance between the physical inferiority and the world around them. Thus it confirms the contention of Allport (1939) that an individual must as a rule either become an aggressor towards his environments or submit to its pressure giving up to the forces opposed to him.

Table 3 shows that chi-square between the median self-disclosure scores of lame and normal boys is significant at .05 level of significance. The number of normal subject in above median cell is 8 and that of lame subjects is 4 in the same cell. The number of normal subjects in the below median cell is 4 and the number of lame boys in the same cell is 8. It means that normal subjects are more self-diclosees than lame boys. Thus, the third hypothesis that lame boys will significantly be lesser self-disclosees than normal boys is accepted. It is possible that because of their handicaps, the lame boys may feel shyness and inferiority and may not disclose their feelings, thinking, wants and wishes to others. Self-disclosure has been proved to be important personality variable (Lubin, 1965 ; Pedersen and Higbee, 1969 ; Halverson and Shore, 1969 and Sinha, 1973). Therefore, low self-disclosure in lame boys may lead to personality disorders if are not properly guided.

The findings of the present study, thus, reveal that lame and normal boys possess almost same degree of anxiety, but the lame boys are significantly more ascendent and less disclosees than normal boys.

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Section III

Problems of Mentally Ill and Emotionally Disturbed

INTRODUCTION

The problem caused by 'Mental Retardation' is an age-old phenomenon. The mentally ill individuals are fundamentally the same as normal persons but only operating at a lower level of intelligence. The mental handicap defined as significantly sub-average general intellectual functioning lacking in intellectual endowment leading to stigmata like prejudice, discrimination and isolation or segregation.

The evils caused by mental handicap or retardation are more a social and national problem. The mentally handicapped constitute a sizable proportion of the population in India, viz. 2% or 13.6 million. They also possess certain amount of potential abilities of which most of the people are not aware. The community, the educated elites, and the high up people have a very vague idea about the mentally handicapped. The victims are usually equated with psychiatric dysfunction where intellectual function is disturbed. It is felt that training may enable mentally handicapped to become happy, productive, and integrated members of the community. It also generally felt that the mentally retardates are not in a position to withstand the fast pace of industrialization and technological development. However, this is found to be untrue in the countries like U.K., U.S.A. and Japan who have absorbed the maximum number of mentally handicapped in various industries.

This section of the book attempts to discover the problems of the mentally handicapped and emotionally disturbed persons. A couple of articles have discussed the social dimensions of mental handicap and the rehabilitation of the victims. The first paper by P.K. Dhillon and Sushma Chaudhry have shown the attitude of various segments of the community including parents, teachers and doctors of normal and retarded children towards the mentally handicapped. The results of the study showed unfavourable attitude of the parents and teachers of normal children and doctors of retarded children towards mentally

handicapped. Whereas the parents and teachers of the mentally retarded have more or less favourable attitudes towards them and the doctors of normal children showed neutral attitude. In the light of the results Dhillon and Chaudhry pleaded for educational programs for the people having negative attitude towards mentally retarded.

T.R. Shukla, in his paper, has highlighted the adjustment and speech problems of mentally sub-normal adolescents. The findings showed that they differ from the normals with regard to adjustment to home area, health, social, emotional and total adjustment. The sub-normals also showed speech problems.

The another article by Manoranjan Sahay is directional. Sahay suggests the need for the help of psychologists, psychiatrists and social workers concerning the problem of mentally handicapped. He also emphasises on the rehabilitation of the neurologically disadvantaged children by psychological techniques. He further suggests for team work for different type of programs to be launched to help the children suffering from neurological problems.

The last article in this section by G.P. Thakur and Manju Thakur compares self-concept and self-esteem of emotionally disturbed and normal females. The findings of this study showed that emotionally disturbed females have higher degree of personally perceived self. The emotionally disturbed also showed different pattern of self-concept as compared to their normal counterparts. No interpretation was given in support of their findings.

The Attitude of the Community Towards the Mentally Handicapped

P. K. DHILLON & S. CHAUDHRI

The problems of the handicapped are not only those that are caused by their disability but also those that are caused by the apathetic or hostile attitude of society towards them which magnifies their problems and even threaten their very existence.

Saiyidain (1959) had pointed out that in India there are millions of children who are handicapped in one way or the other. Of these the blind receive a certain measure of sympathy, the deaf are regarded as objects of good natured amusements, the mentally handicapped are considered to be past praying for and it is only the instructive reverence for life, in the physical sense that keeps them going. So far as the orthopedically handicapped are concerned, they often suffer from perceptible defects of body and movement which tends to set them apart in a class by itself, which is not expected or encouraged to take its full part in social life. The change of outlook on the handicapped that has taken place in other countries has not yet taken deep roots in India and so many of them are still doomed to life of segregation and frustration. Since time immemorial the possibility of having a child who is not normal, either physically or mentally, is so traumatic that often the handicapped child creates disharmony in the family. The parents are torn between two powerful under-currents of emotions, on one side, there is love, on the other feelings of guilt, disappointment and fear. The family of a handicapped child often goes through feelings of guilt, resentment, despair, confusion and isolation. As Schaffer (1964) in a research finding pointed out that if such families do not breakdown there is a strong possibility that they become too cohesive and isolated.

From a historical perspective the social attitudes towards

the handicapped could be said to have passed through four stages : (1) *Exposure and Destruction* : In the prehistoric days, the elimination of the handicapped was achieved by nature, through the operation of the law of 'Survival of the fittest'. Among the early Romans, the father had the right to destroy a deformed child. (2) *Care and Protection* : With the spread of Christian ideals in the West and Buddhism in the East, these practices were gradually abandoned, but still the handicapped were socially looked down upon. (3) *Training and Education* : In the 18th and 19th centuries it was realized that the treatment of the handicapped would relieve society of the burden of supporting the handicapped person throughout his life and (4) *Social Absorption* : Towards the end of the 19th and early 20th century vocational problems of the handicapped attracted the public attention particularly of the more progressive countries of the world. Thus the attitude of society has undergone change through the centuries towards its handicapped are : curiosity, pity, mild dislike or embarrassment, repugnance, indifference, fear and sympathy.

In the history of mankind, there have always been individuals with a limited capacity for comprehending and reasoning, who have suffered in the intellectual capabilities and as such, have been aloof from successful participation in the economic, cultural and social life. A characteristic expression referring to such individuals, who have been utterly neglected, often ridiculed and exploited but never helped, is dumb, stupid, imbeciles and idiots. Even today, the intellectual and complex society with the rapidly growing socio-economic viewpoint has little tolerance for deviancy from established cultural norms. The mentally retarded designated as culturally deviant continue to be rejected and isolated by society. The situation is summarized in the report of Strasbourg Symposium of the International League of Societies for the Mentally Handicapped : ".....to comprehend the handicap, to see what needs doings and to do it, when these three components exist, there is a pulse of communication, between the handicapped person and the rest of the community and every one, not only the handicapped benefits.....In relation to the mentally handicapped these conditions are difficult to achieve...because we do not know what to do, we feel helpless. In the face of human distress which we can do nothing to alleviate we are embarrassed

so we put the problem out of mind and do nothing." Although the ultimate analysis of the aforesaid symposium bluntly points out the shortcomings in the community, but is it true ? Is it not a high time for the community to break all barriers, inhibitions and social taboos and step forward earnestly to appreciate the concern for such 'labeled' individuals ? The social aspect of mental retardation has been a relatively untouched field and there is very little literature available on the aspect. Since every individual has some kind of social affiliation with the community, directly or indirectly, the initiative therefore, rests with it to provide the least but, enough, for self-maintenance. Greenbaum and Wang (1965) concluded that majority of the retardates could be helped to lead socially useful and independent lives if they were able to obtain early, the proper encouragement and guidance. They have expressed their views rather emphatically in the statement : "The likelihood of their doing so depends in great portion on the attitudes and conceptions of mental retardation held by the public in general and in particular by those individuals who have direct contact with the mental retardate at significant times in life."

Problems of mental retardation extend across national boundaries. The problem more or less remains the same at each place. Parents in different lands seem to share many of the same frustrations, needs and, aspirations. The mentally retarded child is always a family problem, always an educational problem and often a social and medical one too. In India, there has been a marked awakening of public and scientific interest in the field of mental retardation, yet the problem of mental retardation remains staggering, overwhelmingly, apalling and challenging. No statistics are available regarding the incidence of mental retardation in this vast country of 684 millions. The financial outlay and the personnel required to conduct a nation-wide survey are not available but some data are available from small sample surveys and institutional sources. However, the size of these estimates vary widely from one another. As Lewis (1960) pointed out that the prevalence of mental retardation is not absolute, but is a conditional estimate, as the cultural values and attitudes of the society have much to do with its recognition. The Social Welfare Department of the Government of India estimated the prevalence of the retarded at 1.8 million (Mehta, 1966) while Marfatia (1966) puts it at

13 million, Boi (1966) at 19.4 million and the World Health Organization reports (1968) assessed the number of mentally retarded to be about 4½% or more than 22 million. The staggaring magnitude of this problem has been summarized by Prabhu (1968) ".....if institutional care is to be provided for all these individuals, we will be in need of more than 48,000 institutions in this country, with the capacity to provide for 50 individuals in each one of them.....from a financial angle if a minimum of Rs. 50 per month is spent on each of these individuals, who reside in these institutions, the total amount required will be a staggering sum of more than Rs. 144 crores a year..." The neglect of this problem in India can be evaluated when there are less than 100 institutions capable of caring for a total of less than 5000 retarded individuals out of the total of over 22 million. But still despits the expansion during the last decade the fringe of the problem has yet to be touched. The picture is gloomy as it is and is bound to be more in the future. As the population is increasing every year at a phenomenal rate it is bound to have its impact on the total prevalence rate of the retarded in the country. Secondly, the present day Indian setting with its rural agricultural economy facilitate the absorption of many of the mentally retarded in menial capacity in the performance of simple manual duties. However, with urbanization and industrialization, this way of absorption is bound to come to an end.

The International League of Societies for the Mentally Handicapped observed that ".....mental handicap in all countries is among the least regarded of social problems. While society; almost everywhere, has come to terms with every other kind of handicap, the mentally handicapped child has been the last to be considered and apart from obeying the impulse to 'put them away', little, until every recent years, has been done. Thus, voluntary organizations for mentally handicapped, in any country, find themselves starting from the same beginnings, working in the same uncultivated field where official knowledge is scarce and public understanding often non-existent..."

The importance of any study, therefore, on the subject is self-evident. Even to this day, in our country, there exists an enormous gulf between the retarded people and the community;

biggest enemy of the retarded being ignorance. People do not know what the 'meaning' of mental retardation implies, hence leading to both incorrect and unfavourable attitudes towards the retarded ; its nature and usefulness of the mentally retarded as citizens. The prejudice of the people around, influences the attitude of the parents and relatives towards the mentally retarded to a large extent as values and attitudes of an individual are developed in accordance with the values and attitude towards the mentally retarded indicate that parental reactions range from viewing him as 'a pet' or 'inhuman Monster' or a 'Curse to bear' (Elliot, 1932) ; parents rate their retarded children less favourable than their normal children (Worchal and Worchal, 1961) ; and parents and relatives of retarded are reluctant to perceive accurately the child's disability (Kramm, 1963 ; Olshansky & Schonfield, 1965). Investigations carried out in India and other countries (Fredricks, 1957 ; Guskin, 1953, Warner et al, 1964 ; Jones et al. 1966 ; Gandhi & Aggarwal, 1969 ; Mujoo & Shukla, 1970) found that mentally retarded children were reacted to much more unfavourably than were physically handicapped children. Tizard and Grad (1961) studying the problems of families and mothers of handicapped children found that : "there were few families that did not comment on the sense of humiliation they felt or had felt on occasions in the past when strangers stared at their child or made comments. Again, neighbours and friends, though sometimes sympathetic and considerate were often indifferent and unhelpful. There were few instances of active hostility but many women commented that they were unable to ask neighbours and relatives to look after their handicapped child as they would have done had the child been normal".

Thus it could be concluded in the words of the Expert Committee of the World Health Organization (1954) that..... Mental retardation is a community problem and whenever, possible the mentally retarded should be served in their own community.. ..."

The community being so important for the welfare of the retarded in particular and the handicapped in general that the present study was carried out to assess the attitude of the community towards the mentally retarded.

Method

Design : A survey research with 'after only-cross sectional

design' with minor modifications was used in the present study.

Sample : Taking into consideration the main objectives of the study purposive sampling procedure was used for selecting the sample. Purposive sampling procedure was adopted because a deliberate effort was made to obtain representative samples of the various groups used in the study. The investigation was carried out in three stages :

The Preliminary study

The try out study

The main study

The *preliminary and try-out study* was carried out for the construction of the semantic-differential scale used in the study. A description of the sample used for the main study is given in Table 1.

The sample consisted of 120 subjects, comprising of six groups of 20 each. The various groups comprising the sample used in the main investigation, the preliminary and the try-out study could not be matched with regards to such variables as age, education, sex, socio-economic status etc. due to the lack of subjects available in the various groups. The various groups were chosen taking into consideration the significance of these *groups in the community and in the lives of the mentally retarded*.

Instrument Used : To measure the attitude of the community towards the mentally retarded a scale based on the semantic-differential technique (Osgood, 1975) with a seven point scaling procedure was constructed on a sample of 170 subjects consisting of six groups (the same groups as used for the main study). After factor analysis 21 bi-polar adjectives with high reliability were chosen and converted in the form of the semantic differential scale. The factor analysis of meaning provides a basis for identifying the attitudinal components of meaning, as attitudes are identified with the evaluative dimension of meaning. 'Evaluation dimension' in the semantic-differential is considered as an index of attitudes.

Administration: The subjects comprising of the selected six groups were approached individually and their cooperation sought. Then the semantic differential scale was given to the subjects and the instructions given were explained as to how to rate the biopolar adjectives on the 7-point scale.

TABLE 1

Showing the description of the sample used in the main study

Group	*Subjects*	*Place of selection*	*Number of sub.*
1	2	3	4
A	Parents of normal Children	Parents of children studying in Central School, R. K. Puram and Air Force Central School.	20
B	Teachers of normal Children	Teachers teaching in Central School, R.K. Puram and Bal Bharti Air Force Central School.	20
C	Doctors of normal Children	Doctors of AIIMS, Irwin Hospital, Military Hospital, Willingdon and Safdarjang Hospitals.	20
D	Parents of the Mentally retarded	Parents who had children in the institutions for the retarded, Okhla Centre, Kasturba Niketan and Lajpat Bhawan.	20
E	Teachers of the Mentally retarded	Teachers teaching in the Okhla Centre, Kasturba Niketan and Lajpat Bhawan.	20
F	Doctors of the Mentally retarded	Doctors of the Psychiatric departments of all the Hospitals mentioned for group C	20
		Total	120

Results : The scoring was undertaken and the analysis of data was done by using the following statistical techniques: Factor analysis, Mann Whitney U test and Kruskall-Wallis one-way analysis of variance. The distribution was not normal and

the sample being small and the nature of the distribution and the characteristics not being known it became very necessary to use non-parametric statistics, i.e. the Mann Whitney U test and the Kruskall-Wallis one-way analysis of variance. Kruskall-Wallis one-way analysis of variance calculated for groups A, B, C, D, E and F on 'Evaluation dimension', or the attitudinal aspect gave a value of 364 which is significant at the .01 level. The significant value indicates that the attitude towards the mentally retarded as held by the different groups is very different from one another.

In order to find out the differences in the attitude towards the mentally retarded as held against different groups the Mann Whitney U test was calculated.

TABLE 2

Showing the significance and U value for the 'Evaluation dimension' (Attitudes)

Groups	*A*	*B*	*C*	*D*	*E*	*F*
	Parents of N-C	*Teachers of N-C*	*Doctors of N-C*	*Parents of M-R*	*Teachers of M-R*	*Doctors of M-R*
A.	—	218	235	312.5**	262*	207.5
B.			255	320.5**	285.5*	221
C.				292.5*	243.5	230
D.					237.5	303*
E.						258

**Significant at .01 level *Significant at .05 level

Table 2 indicates the following findings :

(1) There is no significant difference in the attitude towards the mentally retarded between groups A & B, A & C, and A & F. All of them more or less have similar attitude towards the mentally retarded. (The mean scores of groups A,B, C and F are 2.4, 2.5, 2.6 and 2.79 respectively).

There is a significant difference in the attitudes between groups A & D and A & E. Both the groups D and E are more favourably inclined towards the mentally retarded as compared to group A, that is, parents of normal children. (The mean scores of groups D and E are 3.86 and 3.16 respectively).

(2) There is no significant difference in the attitude towards the mentally retarded between groups B & C and B & F, that

is, the three groups B, C and F have more or less similar attitude towards the mentally retarded.

There is significant difference between the attitude of groups B & D and B & E. Both groups D and E have comparatively more favourable attitude towards the mentally retarded than group B, that is, Teachers of normal children.

(3) There is no significant difference between the attitudes of groups C & E and C & F, that is, Doctors of normal children, Teachers of the mentally retarded and doctors of the mentally retarded.

There is however, a significant difference between the attitude of groups C & D. Group D which constitutes of parents of the mentally retarded have certainly more favourable attitudes towards the mentally retarded as compared to the Doctors of the normal children.

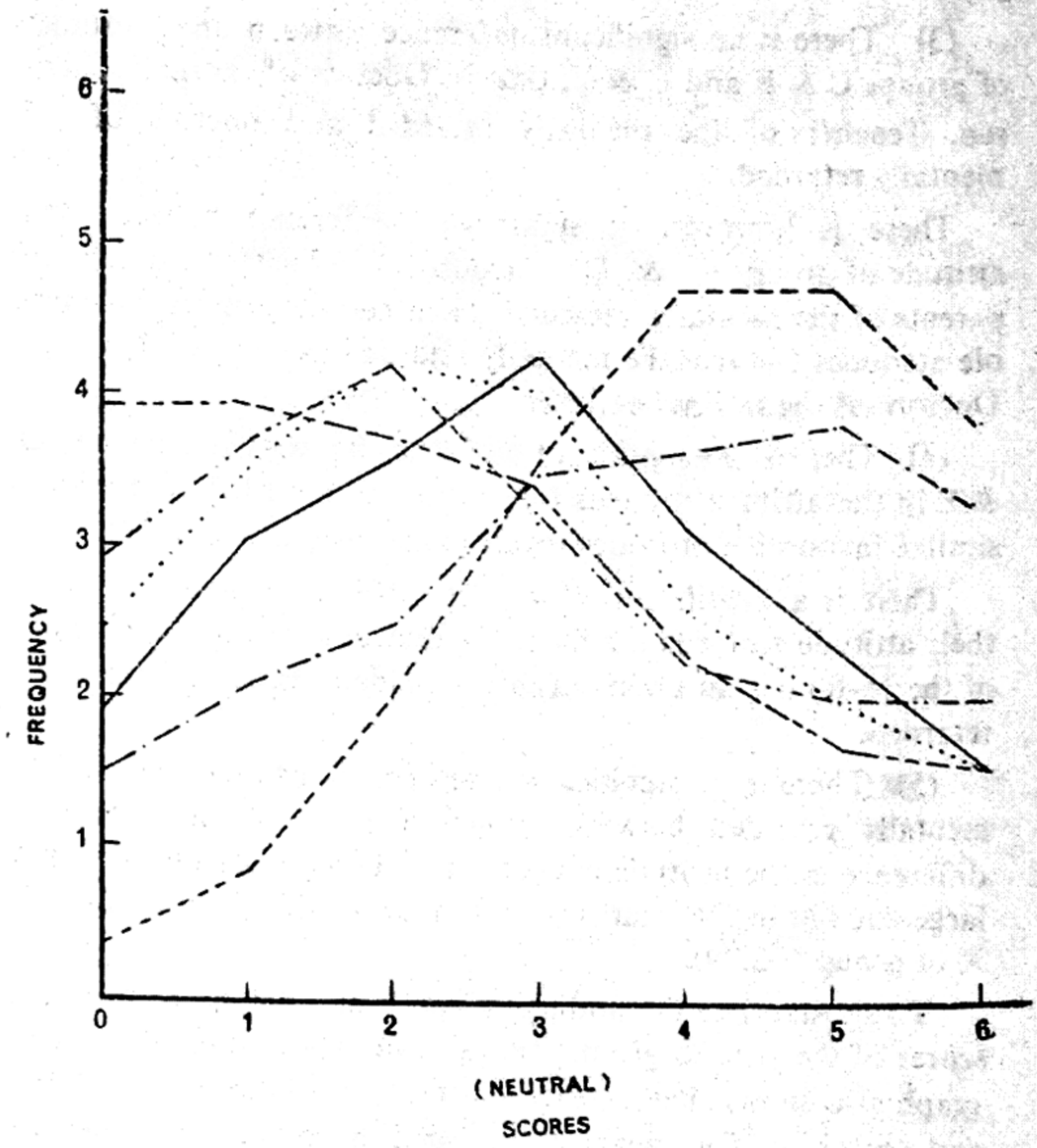
(4) There is no significant difference between the groups D & E in the attitude towards the mentally retarded, they have similar favourable attitudes towards the mentally retarded.

There is a significant difference between groups D & F in their attitude towards the mentally retarded. Group F (Doctors of the M-R) has an unfavourable attitude towards the mentally retarded.

(5) There is no significant difference in attitude towards the mentally retarded between groups E & F, though there a difference in the attitude between the two groups but it is not large enough to be statistically significant (X of group E-3.16; X of group F-2.79).

To substantiate the findings a graph was drawn showing the scores of the various groups on the 'Evaluation dimension'. This graph also shows that parents and teachers of normal children and doctors of the mentally retarded have an unfavourable attitude towards the retarded. Doctors of the normal children have more or less a neutral attitude towards the mentally retarded, whereas, parents and teachers of the mentally retarded have comparatively a favourable attitude towards the mentally retarded. Thus the results of the study indicate that the attitude of the community towards the mentally retarded seems to be negative or unfavourable meaning thereby that an educational programme should be carried out with the object of creating a more favourable attitude or an attitude of

acceptance and non-segregation of the retardates and their families. Without an appropriate attitude on the part of the society it is difficult for parents to bring up mentally retarded children and even more difficult to allow retarded adults to live in the society, enjoy as much independence as possible and



GRAPH SHOWING EVALUATION OF GROUPS
A B C D E & F

..... Group A
— - — - — Group B
———— Group C
— — — — Group D
— . — . — Group E
— - - — - - Group F

work according to their actual capacities.

As far as the general public is concerned the World Health Organization Working Group (1967) has described three principal objectives for public education (1) to prepare the way for acceptance of the handicapped as equal members of society through promoting a better understanding of their problems (2) to arouse and stimulate the interest of people who might wish to make a professional career in or give voluntary help to services for the handicapped and (3) to create a climate of public opinion which will regard the use of public resources in promoting services for the handicapped as a well justified social investment.

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Adjustment and Speech Problems of Mentally Handicapped Persons

T. R. SHUKLA

Introduction

Mental subnormality has been posing problems to every society in various ways, while society has been trying to help mentally subnormals to help itself. But in spite of this being a very important and burning problem not much attention has been paid to understand the adjustment and speech problem of the group. Mentally subnormal children, due to their limited mental capacities are bound to face difficulties in their adjustment in different aspects of life in comparison to normally developed children. "Mental subnormality" is characterised predominantly by an intellectual endowment below the normal and is usually present since birth or soon after birth.

The subnormal child cannot derive benefit from teaching methods of ordinary schools, but requires special attention and training. Problems of mentally subnormal children attracted the attention of educational authorities in France and lot of work began in the direction of construction of intelligence tests to classify the pupils in a special group. But later more attention was paid to the assessment of mental subnormality and adjustment problems of these unfortunate individuals were neglected. Gardner (1966) has recently reviewed the research data on "Social and Emotional Adjustment of mildly retarded children and adolescent". The review of research data shows that little is known concerning the type and frequency of occurrence of behavioural adjustment problems among the mentally retarded. Levinson (1965) found that there were positive correlations between the intelligence and adjustment of mentally retarded in work. Emanuelson (1967) in

a twenty-six year follow up study of mentally retarded children found that mentally retarded find it more difficult to adjust in society in comparison to others in certain respects. He stresses the planned training and education of mentally retarded for their better adjustment in society.

The most common handicap of the subnormal children is poor speech, which results in poor communication. This leads to disturbed interrelationship with parents, teachers and other groups. It also affects ability to be taught, to learn, to interact and communicate, thus bringing a person to a stage of broken individuality, isolated from society. As a result they suffer from emotional disturbances and try to cope in every aspect of life in a maladaptive and immature manner. The present study attempts to throw some light on these problems. It is thus hypothesised that the mentally subnormals would show more adjustment problems in different areas than normals.

Method

Sample : One hundred mentally subnormal adolescents (between 14-18 years of age range) served as the subjects of this study. The sample was selected from the schools for mentally subnormals at Lucknow, Allahabad and Nagpur. Some subjects were also taken from Hospitals at Ranchi. One hundred adolescents of average intelligence between the age range of 14-18 years were selected from schools and colleges at Lucknow, Nagpur and Ranchi.

In this study purposive type of sampling was used in selection of the sample. Both the groups were matched in regard to sex, age, religion, and socio-economic-status.

Tools and Procedure

For assessing the intellect of the subjects Standard Binet Test (Hindi Adaptation by Kulshreshta, 1960) was administered and for knowing the adjustment problems ; Hindi Adaptation of Bell's Adjustment Inventory by Mohsin and Shamshad (1970) was used. To assess the frequency and intensity of speech defects among mentally subnormal group a self made pro-forma for speech disorders was applied. Socio-economic Status Scale (Urban) by Kuppuswamy (1960) was applied to know the socio-economic-status of the subjects.

Analysis of Data and Result

The data obtained from the study were analysed to find out

the mean, standard deviation and percentage for various variables. To find out significance of differences between the means of the two groups *t*-test was used. Results are presented through the tables I to IX.

TABLE I

Showing the I. Qs. of the two groups of the study

Group	*Mean*	*S. D.*
Normal	102.00	5.55
Mentally subnormal	70.00	6.54

TABLE II

Mean and Standard Deviation of the Adjustment Scores in Home, Health, Social and Emotional Areas and Total Adjustment Score of the Mentally Subnormal Group

	Home	*Health*	*Social*	*Emotional*	*Total*
Mean	16.50	14.50	16.00	19.00	71.82
SD	1.82	2.60	3.24	4.10	9.40

TABLE III

Mean and Standard Deviation of the Adjustment Scores in Home, Health, Social and Emotional Areas and Total Adjustment Score of the Normal Group

	Home	*Health*	*Social*	*Emotional*	*Total*
Mean	8.00	8.40	9.80	12.28	45.46
SD	2.88	3.46	3.00	2.10	3.50

TABLE IV

Mean, Standard Deviation and Standard Error of Mean of Home-Adjustment of Mental Subnormal (MS) and Normal (N) Groups

Group	*N*	*Mean*	*SD*	*SEM*	*t*
MS	100	16.50	1.82	.182	17.94
N	100	8.00	2.88	.288	

df 198; Significant beyond .01 level.

Tables clearly show that the two groups under consideration, i.e. Normal and Mentally Sub-normal, differ significantly in regard to adjustment in the home area.

TABLE V

Mean, Standard Deviation and Standard Error of Mean of Health-Adjustment of Mental Sub-normal (MS) and Normal (N) Groups

Group	*N*	*Mean*	*SD*	*SEM*	*t*
MS	100	14.50	2.60	.26	14.09
N	100	8.40	3.46	.346	

df 198 ; Level of Significance .01

The table indicates that Mentally Sub-normal and Normal Groups differ significantly in regard to health adjustment.

TABLE VI

Mean, Standard Deviation and Standard Error of Mean of Social Adjustment of Mental Sub-normal (MS) and Normal (N) Groups

	N	*Mean*	*SD*	*SEM*	*t*
MS	100	10.00	3.20	.324	14.04
N	100	9.80	3.00	.3	

df 198 ; Level of Significance beyond .01

The table indicates that Mentally Deficient and Normal groups differ significantly in regard to social adjustment.

TABLE VII

Mean, Standard Deviation and Standard Error of Mean of Emotional Adjustment of Mental Sub-normal (MS) and Normal (N) Groups.

Group	*N*	*Mean*	*SD*	*SEM*	*t*
MS	100	19.00	4.10	.41	14.58
N	100	12.28	2.10	.21	

df 198 ; Level of Significance beyond .01

The table indicates that Mentally Sub-normal Group and Normal Group differ significantly in regard to emotional adjustment.

TABEL VIII

Mean, Standard Deviation and Standard Error of Mean of Total Adjustment of Mental Subnormal (MS) and Normal (N) Groups

Group	*N*	*Mean*	*SD*	*SEM*	*t*
MD	100	71.82	9.40	.94	26.27
N	100	45.46	3.50	.35	

df 198 ; Level of Significance beyond .01

The table indicates that Mentally Deficient Group and Normal Group differ significantly in regard to Total Adjustment.

TABLE IX

Showing the Percentage of Speech Problems in the Mentally Subnormal and Normal Groups

Group	*Mean I.Q.*	*Mean Total Adjustment*	*Percentage of Subjects having Speech Problems*
MS	70.00	71.82	62%
N	102.00	45.46	1%

It is evident from the above table that many Mentally Sub-normals have speech problems.

Discussion

It was hypothesized that mentally deficient subjects will have more adjustment problems in different areas. Many authors and experts in the field agree that mentally sub-normals, because of their poor mental equipment find it more difficult to adjust and adopt to the demands of the environment in comparison to their other fellow beings who have better mental potentials. Results given in Tables II and III clearly reveal that mal-adjustment scores of mentally sub-normal group are higher in comparison to mal-adjustment scores of the normal group. Mean scores of mentally sub-normal group are higher in all the areas, i.e., home, health, social and emotional. Total mal-adjustment score for mentally sub-normal group is almost double to the total score of normal group.

Normal group of this study shows poorer adjustment in

Social and Emotional area in comparison to Home and Health areas (Table III). May be that they have more problems in social adjustment because the society is changing rapidly and the social changes are taking place due to fast industrialization. Values and norms of living are also changing, because of the influence of Western Culture on Indian Culture. Adolescent may be finding it difficult to cope with the changes. Higher scores in the emotional area are understandable. Adolescent period is characterized as a period of stress and strain. It is a stormy period in the human development, full of conflicts and emotional disturbances. Writers on adolescent psychology emphasize that the emotional upheavals, conflicts and maladjustments are characterstics of this period of "Storm and Stress". During the adolescence the individual is faced with rapid growth, changes in his body proportions and the physiological changes caused by sexual development. At the same time the criteria by which his social status is determined are undergoing modification and his formerly dependent position is changing to one of independence and responsibility which will bring with it marital, occupational and general social status problems. Erickson (1950) has described the adolescence as period of "identity crisis" where an individual is involved in a final definition of his self identity. Spivack (1957) has pointed out that many emotionally disturbed adolescents are not rebelling, but rather searching for self-definition and meaningful standard of conduct to follow. Thus we find that adolescence is a critical period in personality development. Normal group of present study belongs to adolescence period and if they have shown adjustment problems in the emotional areas, the findings are in the expected direction.

Coming to the mentally sub-normal group one finds that highest mal-adjustment score falls in the emotional area. As these subjects also belong to adolescent group, a high score in emotional adjustment area is easily understandable. It has already been discussed that adolescent period is full of crisis for the normal group itself. This crisis is further increased if the subjects are mentally sub-normal, since any kind of adjustment or adoptation requires certain minimum mental potentials. Lower the intelligence more difficult it becomes to cope up with the adjustment problems and chances for maladjustment and emotional disturbances increase. This phenomena has been

clearly demonstrated by the result of the present study. The mean score in emotional area for the normal group is 12.28 and the mean score in emotional area for the mentally sub-normal group is 19.00.

The difference between the scores of the two groups is obvious and statistically significant revealing thereby that mentally sub-normal subjects find it more difficult to adjust in their environment and develop emotional disturbances of greater intensity.

Mean score of mentally sub-normal group is quite high in the social adjustment area. Social adjustment is quite difficult for the mentally sub-normal in comparison to a normal persons with average intellectual equipment. Basically mentally retarded person has the same needs as others. He or she needs love, acceptance, physical care, a sense of adequacy and worth, guidance, and an education commensurate with his mental capacity. Many aspects of these needs can be met by the family unit and by facilities available to all members of the community. But it is often observed that parents and society do not adequately look after the needs of these mentally sunormal adolescents. Either they are over protected or they are looked down. In either case adjustment problems of these unfortunate persons increase. Because of their poor mental equipment, the mentally sub-normals find it difficult to adjust to the demands of the society and get a high maladjustment score in the social area.

Close to the mean score of social adjustment of mentally retarded is the mean score in home area revealing thereby that mentally sub-normal children also have severe adjustment problems in the home area. It is natural for the parents and other family members to care and respect more for those adolescents who are bright and are doing well in school and other areas of life and do not give similar attention to children with poor mental equipment. Some times disappointed parents, insecure and guilt ridden because of their imagined responsibility for the child's mental condition, demand the behaviour and intellectual achievement beyond the child's abilities. Other parents take an overprotected approach in their efforts to shield the child from any challenging situation, thus interfering with the development of whatever capacities he may have.

Social workers have come to place strong emphasis on counselling aimed at helping parents understand and accept the child's shortcomings and make plans appropriate to his capacity. Thus in the given circumstances it is not surprising that mentally sub-normal adolescents have more maladjustment problems in the home area.

Coming to the adjustment in the health area one finds that in comparison to other areas mentally deficient group gets lowest scores, although these scores are much higher in relation to normal group of subjects. Thus we find that in comparison to normal group mentally deficient subjects have more problems in othera reas. This trend may be there because adolescent period is full of energy and vigour and they may not be much worried about their physical problems.

Total Adjustment of the Two Groups

Data in regard to total adjustment of the two groups are given in the Table VIII. Mean score of Normal group is 45.46 and S.D. is 3·50 and mean score of the mentally dificient group is very large. The '*t*' test was found to be significant beyond .01 level of significance indicating thereby that overall adjustment of mentally deficient group is extremely poor as compared to the adjustment of the normal group.

Speech Problems

It is evident from Table IX that 62% of the mentally subnormals of this study have speech problems. These speech problems include defects of word-meaning, defects of pronounciation, defects of symbolization, echolalia and defects of articulation. Mentally subnormals do not have intellectual capacity to adopt, grasp and understand normal and correct ways of communication and adopt poor forms of communication further aggravating adjustment problems.

In conclusion one can say that mentally sub-normal adolescents have more adjustment problems than the normal adolescents in the four areas of adjustment, i. e. Home, Health, Social and Emotional. Also that overall adjustment of mentally subnormal group is very poor when compared to overall adjustment of the normal group. Group differences are highly significant for all the area of adjustment. It was further revealed that many mentally subnormals have speech problems.

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Beyond Medicine and Surgery

M. SAHAY

Medicine and Surgery are never the final answer to any disease or accident. We often come across a number or diseased children where even the best medicines and surgical techniques utterly fail or cannot ameliorate the condition after certain level of success, for example, all attempts to increase intelligence in a mentally subnormal child have invariably failed. The child becomes a 'disadvantaged child'. Unfortunately, in a disadvantaged child, the disadvantages are one (2, 3, 4, 5 & 6). A disadvantaged child is usually a multifacet entity having coexistence of neurological, psychiatric, psychological, educational and social problems. We often find a Schizophrenic-Like-Psychosis in a mentally retarded child. Cerebral palsy involves damages to the brain tissue due to defective development, injury, insufficient oxygen reaching the brain of the neonate, premature birth, incompatible RH blood factor or infection of the mother with German measles during pregnancy. Such children arouse a natural pity among people around him which changes their attitude towards him. Consequently he developes a number of psychological problems.

Thus, a neurologically disadvantaged child will also need the help of a psychologist, psychiatrist and a social worker. A complete and meaningful treatment of disadvantaged children essentially require also a number of skilled para-medical staff with specialised knowledge. The substitution of a mosaic approach for traditional diagnostic approach would surely benefit such children.

Rehabilitation, Team Work and their Problems

A child-rehabilitation centre is a hospital for chroncially disadvantaged children patients who are prepared to cope, as much as they can, with the outside world. We have to bridge up the gap between such centres and community living. Making the transition from Institute to community life is the ultimate aim of Rehabilitation Centre.

The goal of making the disadvantaged child an asset to the society can be successfully achieved only with team-spirit in a Rehabilitation Centre. The neurologist, the psychologist, the social worker, the educator, the nurses and child care-taker must work in harmony. Each worker should be ready for dynamic changes. When the disadvantaged child improves on account of illness-oriented treatment, we often have to shift to health-oriented programmes, which may cause professional-conflicts. With a proper communication and ready willingness on the part of the workers to give up their "Specialists' bias" in the interest of the child would facilitate the resolution of such conflicts and successful rehabilitation can be achieved. Each specialist has to modify his goal to suit the other. A sense of respect to each other's speciality is a fundamental basis of a good team-work. Team-workers must be capable of handling sexuality during the periods of latency and adolescence. The child's view-point must be given adequate attention.

Indian Economy and Society vs Rehabilitation

India is poor but rich in unemployment. A natural sense of insecurity about the employment prospects of able children prevails among their parents. It is any one's guess about the state of mind of the parents and the rehabilitation-workers about the employment prospects of the disadvantaged children. Moreover, the employers are certain about a healthy worker's preference over a disadvantaged one, for fear of higher compensation, injury on account of disabiility (say Seizure), high absenteeism resulting in loss of production and above all the unfavourable reaction of the able employees toward the disabled ones. However, now we have the data to prove that these fears are nothing but 'anxiety', i.e. fear exagerated disproportionately to the real situation. Josep J. Melone of University of Pennsylvania, observes that the fear of higher compensation is not realistic. The mortality and medical claim experience of persons with epilepsy are not higher than average experience. The average employer would have only few disadvantaged workers and hence even if there is additional cost it would be relatively small to the total benefit. If the employer is anxious of higher mortality, he should also think less load of retirements.

The task of opening the employment-prospects for the

disadvantaged child has to be initially tackled by the rehabilitation team. Of course, they may not change the dismal picture of Indian economy, but there is enough scope of utilizing the available meagre resources for such children. The public at large has to be educated that a disadvantaged child can be made able-disadvantaged. Today one epileptic need not be regarded as second class citizen.

The myths about the disadvantaged child have to be eradicated.

Mingle the Minority with the Mainstream of Majority

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A Comparative Study of Self-Concept and Self-Esteem of Emotionally Disturbed and Normal Adolescent Females

GIRIDHAR P. THAKUR AND MANJU THAKUR

The concept of a person regarding his own self has been mostly described in the psychological literature as 'Self-Concept' or 'Self-Esteem'. These two words have mostly been used interchangibly but, in fact, both the self-prefixed words do have different connotative meanings. Cooley (1902), perhaps for the first time, presented most widely used and accepted definition of 'Self' ".....that which is designated in common speech by the pronouns of the first person singular, 'I' 'Me' 'Mine' and 'Myself". The 'Self' is established when an individual is aware of being a separate entity, existing completely detached from objects within his environment (Calhoun and Morse, 1977). The 'Self' is acknowledged very early in child development.

Once the person becomes aware of his 'Self' the next stage of development is the formulation of a concept of that self. This part of development is based on the social interactions and experiences achieved from these encounters and the degree of success derived from such experiences. Successful experiences result in more positive 'Self-Concept' and vice versa. Self-Concept, therefore, refers, to how a person perceives himself in terms of ability, worth, value, etc. Rogers (1974), for example, has defined 'Self-Concept' as ".....the sum total of all the characteristics a person attributes to himself, and the positive and negative values he attaches to these characteristics". Combs, Soper and Courson (1963) have defined "the Self-Concept is what an individual believes about himself, the totality of his ways of seeing himself".

Self-esteem develops later involving an additional evaluative component described as "satisfaction". Self-esteem arises

out of the child's ability to estimate his own strengths and weaknesses. Allport (1961) is of opinin "pride is one common synonym of Self-esteem, Self-love another". Elder (1968) defined Self-esteem as "feelings of personal worth.....influenced by performance, abilities, appearance, and judgments of significant others".

In this brief description of the words it is evident that in a person 'Self-Concept' develops earlier than 'Self-esteem'. It is also evident that 'Self-Concept' tends to remain a more stable, constant phenomenon while 'Self-esteem, may fluctuate from time to time. Gergen (1971), for example, has considered Self-esteem, to be neither global nor fixed. If this is true, there is a possibility that a person may have a positive 'Self-Concept' and, yet a negative 'Self-esteem' concurrently. Calhoun, Warren and Kurfiss (1976), while making a distinction between the two concepts, have described self-concept as "the way an individual perceives himself and his behaviour, and his opinion of how others view him" and self-esteem as "the individual's satisfaction with the self-concept".

The self of an individual deeply affects adjustment to himself as well as other people of the society. It would, therefore, be an interesting point to ascertain patterns of self-manifestation in relation to adjustment in life. The present study is an effort to this direction.

METHODOLOGY

Sample. 48 emotionally disturbed and 48 normal unmarried adolescent females of Bihar constituted sample of the study. Their ages ranged from 16 to 19 years with a mean age of 18.56 year. Clinicians described these emotionally disturbed females as suffering from one or the other form of neurosis but they were not psychotics. Normal female adolescents were selected randomly from the college population. Except persistent emotional problems in one group both the groups were comparable on other variables viz. social status, education, economic background, etc.

Tests. Self-Concept was measured with the help of a modified inter-personal check-list originally developed by Preston (1966). Only 33 items of the check-list were used for the present study. The suitability of the check-list in Indian conditions had been indicated in the literature (Anantharaman, 1981).

This check-list contained positive aggressive items, negative aggressive items, positive docile complaint items and negative docile complaint items. The subject was expected to indicate if these qualities were present in him or true of him.

Self-esteem was assessed with the help of an inventory (Prasad and Thakur, 1977). This inventory provided scores on two aspects of self-esteem viz : personally perceived self and socially perceived self. Personally perceived self indicated how, he thinks of himself and socially perceived self indicated how, in his opinion, he was being perceived by other members of the group.

The inventory had 30 items in the Likert format of which 17 were socially desirable and 13 were socially undesirable. The response format contained 7 points ranging from 'very true' to 'completely false'. Positive items could score 7 for response 'very true' and 1 for 'completely false'. The negative items were scored in the reversed manner. The maximum possible score one could get on each aspect of the inventory was 210 and minimum 30. On the basis of the scores it could be determined whether the individual had a 'positive' or a 'negative' or a 'balanced self-esteem'.

The check-list and the inventory were presented individually to the subjects at their convenient time. Since both the tools were in Hindi there was no difficulty in understanding them.

Hypotheses. The following hypotheses were tested:—

1. Emotionally disturbed adolescent females and normal adolescent females would have different pattern of self-concept.
2. Emotionally disturbed adolescent females would differ significantly from their nomal counterparts on the two aspects of the self esteem, and ;
3. Emotionally disturbed adolescent females would have higher degree of personally-perceived self in comparison to socially-perceived self.

RESULTS AND DISCUSSION

With a view to ascertaining self-concept of the two groups viz ; emotionally disturbed group and normal group percentage of endorsements were worked out. The results are reported in Table 1.

TABLE 1

Percentage of Endorsements

S.N.	*Adjectives*	*Normal Group*	*Emotionally disturbed group*
1.	Forceful	43.64	45.53
2.	Good Leader	39.51	41.32
3.	Dominating	52.92	30.17
4.	Manage others	46.42	44.54
5.	Often admired	43.42	43.14
6.	Respected by others	48.42	46.41
7.	Feel very important	39.42	46.12
8.	Expects everyone to admire	49.46	46.12
9.	Independent	44.12	49.61
10.	Self confident	65.14	42.16
11.	Boastful	46.15	64.16
12.	Self satisfied	39.41	18.96
13.	Can be indifferent to others	36.94	35.51
14.	Like to compete with others	31.91	61.65
15.	Shrewd and calculating	31.32	24.16
16.	Cold and unfeeling	33.12	36.31
17.	Frequently disappointed	40.15	61.52
18.	Skeptical	35.16	45.65
19.	Touchy and easily hurt	30.32	46.15
20.	Able to criticise self	52.14	31.45
21.	Shy	31.94	60.66
22.	Can be obedient	50.14	35.16
23.	Friendly all the time	45.15	29.15
24.	Kind and re-assuring	50.10	35.00
25.	Over sympathetic	40.15	60.16
26.	Too lenient with others	35.16	65.16
27.	Over protective	46.16	61.15
28.	Warm	36.12	31.15
29.	Appreciative	31.15	35.16
30.	Apologetic	27.15	26.37
31.	Able to doubt others	30.35	35.14
32.	Hard to impress	36.15	41.15
33.	Resentful	30.16	35.15

It is evident that the emotionally disturbed group had almost negative self-concept. This group appeared to be skeptical, boastful, frequently disappointed, touchy, over

sympathetic, competitive in nature, doubting others, shy lenient, over protective and resentful. The normal group, on the otherhand, appeard to be friendly, self satisfied, obedient, self critic, self-confident, and dominating. It may also be noted that on the other adjectives the difference between the two groups was marignally small. On some more items the difference might be expected but, perhaps, due to social-desirability it did not come. Mean scores of the two groups on self-esteem along with SDs are presented in Table 2.

TABLE 2

Mean and SD of the two Groups

Dimensions	*Normal Grunp*			*Emotionally Disturbed Group*		
	N	*Mean*	*SD*	*N*	*Mean*	*SD*
Personally perceived self score (PPSS)	48	168.52	11.74	48	188.56	13.92
Socially perceived self score (SPSS)	48	163.32	16.59	48	136.53	12.71

It is clear from Table 2 that the normals had lower mean scores on the personally perceived self (PPS) as compared to the emotionally disturbed group. On the socially perceived self (SPS) the finding was reversed i.e. emotionally disturbed group had lower mean value than their counterpart. One observation, however, was similar for both the groups, i.e. both the groups had higher mean scores on the personally perceived self dimension as compared to the socially perceived self dimension.

An attempt was made to put mean scores of both the dimensions of self-esteem of the emotionally disturbed group to student's *t*-test of significance. The results are reported in Table 3.

TABLE 3

Student's *t*-test of Significance

Groups Compared	*N*	*Mean*	*SD*	*t*	*df*	*p*
PPSS of emotionally disturbed group	48	188.56	13.92	19.19	94	.01
SPSS of emotionally disturbed group	48	136.53	12.71			

A look into Table 3 would reveal that emotionally disturbed group had lower mean value on the socially perceived self dimension, the values being 188.56 for personally perceived self and 136.53 for socially perceived self. This group, therefore, viewed self more positively and, they felt about others of not viewing their self in the same way. The mean difference was significant at or beyond 1% level of confidence, the value of *t* being 19.19 with 94 df. Similarly comparison was made for the normal group and the results are reported in Table 4.

TABLE 4

Student's *t*-test of Significance

Groups compared	*N*	*Mean*	*SD*	*t*	*df*	*p*
PPSS of normal group	48	168.52	11.74	1.78	94	NS
SPSS of normal group	48	163.22	16.59			

Table 4 reveals that the normal group did not differ significantly on their mean scores of both the dimensions of self-esteem. The mean values of personally perceived self and socially perceived self were 168.52 and 163.32 with 11.74 and 16.59 SDs. The obtained *t* value was not significant at or beyond 5% level of confidence the value being 1.78 with 94 df. The observed mean difference, therefore, had come due to chance factor. Such a correspondence between the two dimensions of self-esteem is helpful for better adjustment in life.

Further, an attempt was made to compare the two groups viz; the normal group and the emotionally disturbed group on personally perceived self and socially perceived self separately student's *t* test of significance. The results of such comparisons are reported in Tables 5 and 6.

TABLE 5

Student's *t*-test of Significance

Groups compared	*N*	*Mean*	*SD*	*t*	*df*	*p*
PPSS of normal group	48	168.52	11.74	7.67	94	.01
PPSS of Emotionally disturbed group	48	188.56	13.92			

TABLE 6

Student's *t*-test of Significance

Groups Compared	*N*	*Mean*	*SD*	*t*	*df*	*p*
SPSS of normal group	48	163.32	16.59	8.90	94	.01
SPSS of emotionally disturbed group	48	136.53	12.71			

A look into Table 5 would reveal that emotionally disturbed group had higher mean value on personally perceived self dimension as compared to the normal group, the mean values being 188.56 and 168.52 respectively with 13.92 and 11.74 SDs. The obtained *t* value (7.67) was significant at or beyond 1% level of confidence with 94 *df*. High self rating by individuals of themselves might cause emotional disturbance as this created a gap between the two aspects of self-esteem. More gap between the two aspects of self-esteem would result in more poor adjustment would naturally result in emotional disturbance.

Table 6 shows that the normal group had comparatively higher mean value on the socially perceived self dimension and the emotionally disturbed group had lower mean value. This difference was also significant at or beyond 1% level of confidence. The mean values were 163.32 and 136.53 with 16.59 and 12.71 SDs. The obtained *t* value of 8.90 was significant at or beyond 1% level of confidence with 94 *df*. Emotionally disturbed group was suffering, perhaps, because of the gap of ratings on both the dimensions. It would, therefore, be advisable to improve their social relations to the extent possible and improvement seen.

The findings of the study might be presented hypothesis-wise. The study revealed that :

(i) Emotionally disturbed adolescent females showed different patterns of self concept from their normal counterparts.

(ii) Emotionally disturbed adolescent females also differed significantly from their normal counterparts on the personally perceived self and socially perceived self aspects of self-esteem, and;

(iii) Emotionally disturbed adolescent females had significantly higher degree of personally perceived self as compared to socially perceived self. All the hypotheses, therefore, were accepted.

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Section IV

Problem of the Handicapped : Theoretical Interpretations

Introduction

Handicap of any kind is sufficient to limit a person's mobility in the society in a number of ways. His physique and appearance are important criteria in impressionistic social classification. A handicapped person's role, status and behaviour in society is very much influenced by interpersonal behavior, impression formation, liking, etc. shown by other members of the society. This is why the visibly handicapped like others learn the specific culture values (both positive and negative) attached to aviations in physique and appearance. The sympathetic responses, the negative or hostile reactions or indifferences in behaviour shown by others influence the attitude of the handicapped towards the society. This results in the form of withdrawal, maladjustment and non-participation in the social world. Disability is not only a medical matter, it is an area of concern for the social psychologists. According to Meyerson (1955), it is not an 'objective thing in a person but a social value judgement'. Social value and judgement are quite important for one's adjustment and integration with the society and community. Society's perception of his 'deviance' lessens the possibilities of understanding his interests aspirations etc. This tends to withdrawal by handicapped against the discriminations, hostility and indifferences.

This section of the book is concerned with society's attitude and concern towards handicapped persons. The papers in this section, by and large, are confined to the problems of the physically handicapped. In the first paper Qamar Hasan highlights the society's discriminatory attitude towards the haddicapped. Hasan vehemently criticises the notion of describing the handicapped as separate class especially on labeling them as 'psychology of handicapped', 'psychology of gifted' etc. In the light of empirical findings he claims that they are not psychologically different from others. On a number of psychological dimensions he argues that the handicapped, especially the visually impaired, are not different from their normal

counterparts. Hasan also considers social forces responsible for the handicapped being treated as separate class.

S. Narayanan describes handicap, especially the physical handicap, responsible for inducing inferiority complex and inconsistency in relationships. He describes the compensatory behaviour by the handicapped in the light of Adler's concept of striving for compensation. Narayanan holds parental roles and social marginality responsible for personality development. Both rejection and overprotection influence the development of personality. He also thinks that the negative attitudes by the society leads to distortion of their personality. He stressed the need to foster creativity among them as a matter of compensation.

Arif Hassan in his paper critises the neglecting tendency of the society towards the handicapped. Hassan warns against growing population in the third world in general and in India in particular. He stresses the need for various rehabilitation and education programs, medical treatment, and preventive measures. He labels the negligence of the handicapped as 'Blindness of the Society'.

In the last paper of this section K.P. Krishna looks into the concept, classification, and extent of physical handicaps and their psycho-social problems. Krishna has presented a survey of different types of the handicapped and has put the physically handicapped on top of it. He lists the problems the handicapped face including emotional trauma, frustration in life and social stigma. He also stresses the need for an effective role of social scientists on their placement, adjustment and rehabilitation. Besides suggesting the psychological evaluation and counselling for them he also emphasises on the need for the identification of their problems and potentials. Lastly, Krishna emphasised for collective efforts by the community and social scientists to bring awareness among the common masses.

Problems of the Handicapped: Their Social Roots and Psychological Offshoots

QAMAR HASAN

Psychological problems of the handicapped are intricately enmeshed in the matrix of social attitudes towards the group. The belief about the range of individual differences is the first to be discussed and its implications for the problems of the handicapped are to be highlighted.

Many pretend to believe in the democratic principles of equality and abuse this principle in fabrication of rationalizations about their unsympathetic treatment of the handicapped. Disregarding the fact that the handicapped are not capable of going beyond their limitations, many people are not capable of going beyond their limitations, many people are not willing to revise their demands and expectations from them.

The employer who insists that he does not discriminate against the handicapped and yet is unwilling to lower the criterion of efficiency is blocking the entry of the handicapped and finds it difficult to get rid of facade of civility which would be off if the door is slammed.

On the contrary, exaggerated emphasis on the range of individual differences is the continuation of, what Jung would term, as racial unconsiousness of the medieval era. In that period deformity triggered such ideas as the devil, the sin and the devine wrath. The contemporary expression of medieval mentality take the form of following rationalization:

"We naturally do not employ the afflicted when we have sound material at hand. Taken as a whole even when fitted to job they are apt to prove less satisfactory, because of accompanying mental state of depression and nervousness" (Quoted by Kessler, 1947).

A polite excuse for closing the door against the handicapped is that they are more prone to accidents. Those who believe in

the myth of accident proneness of the handicapped will be surprised to know the findings of a survey reported by Kessler (1947). The survey showed that the individual prone to accident is the one who is maladjusted rather than the one who is disabled. It may be noted that the survey covered the population of workers which included 8,000 disabled. Kessler (1947) concluded, "though the causation of accident may be traced to technical and human factors, physical defect is not a major cause".

The belief that the handicapped is critically different from others is the main source of social problems they have to face as a group. Like other 'different' people, disabled have been relegated to the status of minority and ethnic groups. (Barker, 1948; Tenny, 1953, Wright, 1960). The treatment which the minority of the disabled receive from the majority of non-disabled is well stated in the following excerpt :

"The non-disabled majority tend to maintain a certain social distance, often treating the disabled as outsiders. Many people feel uncomfortable in presence of a disabled individual. They find it difficult to accept and with the disabled as they do with other people, and since they have great prestige and power, they can restrict the opportunities of the handicapped" (Telfrod and Sawreg, 1967).

A well known principle of perceptual dynamics is that objective reality is forced to appear in the form of preconceived notions. However, when transformation of reality is restricted by overwhelming evidence contrary to subjective forces of the dynamics, the natural gift of reasoning is abused in rationalization against exception to expectations. Thus, when a disabled does not suffer with inferiority feelings, when he behaves as others do, when he excels others in certain areas. when he self-actualizes through creative activity. he is supposed to employ defense mechanisms of reaction formation, over compensation and sublimations. Yet another expression of prejudice against the handicapped is using the specific disability as the basis impression of the persons as a whole. This process is akin to halo effect observed in ratings of personality characteristics. Halo effect refers to the consequences of a generalized mental attitudes which lead the clustering of either positive or negative traits in assessing the traits of the ratee. Thus, the disabled is seen not as merely suffering from

certain incapability, but as a embodiment of all the defects which one would not like to recognize in himself, and would, therefore, project on to convenient target. It is due to prejudiced mentality that we pay little attention to the simple fact that "there is nobody in the world that's totally able and there is nobody in the world that is totally disabled. We all have things that we can do very well and things we can't do".

While engaged in the professional assignment of personality assessment, the psychologist, in his attempt to remove halo, does not spare any stone unturned, but he commits the error of generalization when he talks about 'Psychology of Exceptional Children', 'Psychology of the Handicapped'. One wonders whether the disabled and non-disabled have two sets of primary and secondary motives, dispositions, defenses and belief systems; one of which is exclusively reserved for the former and the other for the latter. Psychologists who use such terminology as 'Psychology of the Handicapped', 'Psychology of the Physically Healthy Man', should realize that this implies :

(*a*) that able-bodied and disabled are two discreet categories,
(*b*) that single disability causes total restructing of personality,
(*c*) that all kinds of handicaps, *e.g.*, visual, orthopedic, cognitive, socially disabled, etc., have to face similar problems, or at least have to make use of same adjustment mechanism.

Obviously, none of the above statement is sound. On the contrary, it can be asserted that, "the laws governing adjustment to disability are the same as those governing adjustment to any other condition" (Loquist, 1960).

Besides, argument and empirical evidence that can be furnished on the basis of what is reported by others, a recent study carried out by Hasan, Khan and Khan (1982), failed to support that visually handicapped are a lot of maladjusted and cynical people. Blind adolescents were asked to complete fourteen sentences presented to them in Braille. Words added to each complete sentence in Braille were transcribed with the help of a blind university student. Incomplete sentences were formulated for getting the following information : (1) Purpose of getting education, (2) The main desire, (3) Characteristics of disliked people, (4) The main difficulty due to lack of eye sight, (5) Treatment meted out by the sighted

people, (6) How the blind can lead a better life, (7) Attribution of responsibility for difficulties in life, (8) Deprived of sight, what the blind feels about God, (9) What the blind thinks about the World, (10) Limitations caused by blindness, (11) Thinking about marriage, (12) Demands of life due to lack of vision, (13) Conditions that could lead to better life, (14) What the blind expects from the sighted.

Main conclusions of the study are :

(*i*) 28% of the subjects reported negative feeling tone associated with despair, shame, bitterness, apprehensions about being accepted by others.

(*ii*) 36% of subjects reported positive feeling as expressed through hope, expectation of receiving love and affection from other, and confidence in one's worth.

(*iii*) 36% of the subjects were ambivalent in their feelings.

On the basis of content analysis it was found that majority of blind people think that sighted people love and sympathize with them. Movement and reading are the most frequently reported difficulties, responsibility for difficulties in life is usually attributed to God and oneself with equal frequency. Most of the blind expect to get married. Most frequently reported ways of leading a better life are : becoming self-supportive, maintaining harmonious relations with others, and avoiding quarrels.

The findings of the present study lead to the conclusion that most of the blinds are not dependence prone, frustration prone, and embittered. Some of them are disappointed but the same is true for some of the sighted.

Having a look on the problems of the handicapped that are contingent on lack of moderation in views about the range of individual differences, some of the problems of the handicapped, but not definitely peculiar to them, are to be considered. It is to be reiterated that most of the problems to be discussed are rooted in adverse social evaluation of the limitations of the disabled. Some of the psychological problems of the handicapped are :

(1) **Somato-psychological problems**: Problems of psychosocial adjustment arising out of self and other's reactions to a typical physique are known as somato-psychological problems (Wright, 1960). Psychologist working in the field of somato-psychology draw a distinction between handicap and disability.

Disability is used to denote objectively defined impairments of structure or function; the term handicap refers to cumulative effect of disability and personal and social consequences which have determental effects on the individual's functional level. Obviously, the distinction signifies an emphasis on situational set-up in which the disabled is to live and operate. The handicapping effect of adverse reactions can well be understood if it is realized that the visibility of the deformity is one of the important factors underlying psycho-social problems of the handicapped.

Nevertheless, reactions to personal-stimuli are not peculiar to amputees, blinds, or facially disfigured persons. Renewed research interest in cognitive and effective connotations of variations in body build can be observed in studies carried out by Learner (1969a, 1969b), Learner and Korn (1972), Iwawaki and Learner (1974). The most outstanding findings of these studies is that certain stereotyped behavioural expectations are associated with Mesomorphic, Ectomorphic and Endomorohic physiques.

Of late much attention is concentrated on body-image-attitudes of the disabled. As a matter of fact body concepts have been introduced into personality theory apropos of serious body handicap or deformity. The process of body image formation that lay the foundation for future development in children can be described as below :

"As a normal child matures, he at first unconsciously, and subsequently in academic way, learns ahout his body, his body shape, his movement capabilities, the relationship of body parts to events, near and distant space and the names of specific body movements and body parts" (Cratty and Sams, 1968).

Interest in the study of gross kinesthetic stimulation and infant's heightened awareness of own body, led Fraiberg and Freedman (1964) to emphasize the need of bringing prepared environment to the visually disabled. This was expected to give the blind the benefit of experience of his own body moving about the environment. The importance of body-image programmes in school, is also stressed by Walker (1973). Walker assumes much correspondence in body-image formation and intellectual development.

2. Denial of Disability : While considering somato-psychological problems reference was made to visibility of the defect. Although visibility of the defect attract contemptuous attention, denial of disability and attempt to cover it up may give rise to certain difficulties. People often resist the use of canes, crutches eyeglasses, and hearing aids, even if it leads to functional impairment. Attempts to hide the defect are sometimes made by parents who are ashamed of their deformed offspring. Since the price of "as if" behaviour is high and exposure leads to trauma or at least to embarrasment, the disabled should be encourged to accept his limitation without succumbing to them. The mannerism of hard of hearing persons who avoids to utter "what", or try to cover up by talking all the time and giving little opportunity to others to speak, or by faking daydreaming, absent mindedness, boredem and indifference, may cause more difficulties in interpersonal relations.

3. The Problem of Negative Self-Concept : Self-concept denotes an individual's evaluation of his worth and limitations in all those aspects of which he is aware of. Since evaluation requires feedback on effectiveness of one's operant and respondent behaviour, and since one is immersed in the matrix of interpersonal relationship, feelings and attitudes of significant others, viz., peers, teachers, neighbours, and especially parents, have much to contribute in the formation of self-concept. Physique being an important personal-stimulus, for stereotypic impression and behavioural expectations, the disabled is likely to receive cues of negative evaluation. Meighan (1971) found that self-concept measures of visually handicapped were extremely low on physical moral-ethical, and indentity items. Lukoff and his associates (1972) reported that the disabled often feel that their conditions prevent others in recognizing their positive attributes and that visual disability penetrates all the relationships which they would like to engage.

The importance of giving cognisance to individual's self-concept for rehabilitation programme was highlighted by Fishman (1962), who reported that prediction of outcome of rehabilitation programme based on evaluation and nature of disability was less accurate than the one in which person's unique perception of disability and his self-concept were considered.

4. Anxiety level : Threatened by demands of life and

confused by ambivalent attitudes towards himself the handicapped is likely to suffer from anxiety state. Consequently he may restrict his sphere of activities, keep his aspirations low and suffer from fear of failure. The disability super imposed anxiety is, therefore, one of the important antecedents of decline in ability to cope with demands of life. Diminished coping capability is often expressed through impulsive, compulsive, and rigid behaviour as also as through incoherent thinking.

The discussion of such problems of the handicapped as somato-psychological reactions, distortion of body-image and low self-esteem, etc., may be posed as the acknowledgement of claim that the handicapped is critically different from the non-handicapped. It is to be reiterated, however, that psychological problems of the handicapped are delicately enmeshed in the matrix of social and interpersonal factors. Roger (1939) claimed that if one wants to predict the outcome of treatment on the basis of a single factor, it would be better to disregard the child entirely and concentrate on emotional climate of the home. Such reactions of the parents towards the disabled as shock and disbelief, denial, anger, guilt, frustration, depression, reorganization and adaptation have much to contribute towards the feeling of helplessness or self-confidence. Myerson (1963) and Ross (1964) seem to have made a valid claim that even in motor or sensory loss-blindness, or deafness, or crippling the psychological significance of the condition has to do, in large measures, with such matters as actual or threatened social isolation, personal independence, and acceptance of personal limitations, experiences which all human being have. Sympathetic and unprejudiced attitudes towards the disability and certain environmental provisions can be of much help in removing the barrier in the hadicapped's way of self-sufficiency and self-actualization. Provisions like stairs as well as ramps, doors wide enough for wheel chairs, restaurant having few copies of menues in Braille, flashy light as well as fire alarms that sound, elevator button low enough to reach, etc., can be of much help in making the environment accessable to the handicapped.

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Psychological and Social Perspective of Handicapped

S. NARAYANAN

Physical handicap may influence an individual in his behaviour. It may induce inferiority feelings or complex in the individual, contribute to an inconsistency in relationship among the parents and the handicapped, and could even conduce social margiality. It is plausible that these individuals and social factors may construe certain disturbances in personality of the handicapped. Such an hypothesis has received general confirmation in the work of the author in the field of acoustically handicapped adolescents. Admittedly, the handicapped do possess potentialities for development as a full independent individual. Society should create and provide conditions for creative development of the handicapped and foster their creative being.

Organ Inferiority and Striving for Compensation: Adler (1924), and Ansbacher and Ansbacher, (1956) have emphasised that feelings of inferiority constitute a source for striving for compensation. The striving for compensation of the inferiority experienced by the individual shapes the life style. According to Adler, every individual attempts to overcome his feelings of embarrasment and thus behaviour remains to be a function of his strivings to win his feelings of inadequacy. The trends of behaviour arising from the individual's attempts to compensate his inferiority gradually assume definite pattern which becomes life style of the individual. Thus, the type of inferiority experienced by the individual and the consequent striving or compensation may have far reaching effect on the personality of the individual. Organ inferiority, in other words, the physical handicap may be hence identified as one of the conditions leading to typical compensatory striving behaviour on the part of the individual. It is, therefore, recognised that the physical handicap may reflect itself in the personality of the individual.

Parent-Child Relation and its Effect on Personality : Parents adopt different styles of relationship with their children and these styles influence the personality development of the children in different ways (Hurlock, 1969 ; Sim, 1969 ; Narayanan and Ganesan, 1977). Handicapped children evoke conflicting reactions among their parents. Parents of handicapped experience difficulty in accepting their children. Ambitious parents shun having their children as handicapped ones. They may unconsciously tend to reject or punish their handicapped children. Parents develop over sympathy spontaneously or as reaction formation and in both the cases are unrealistic in their understanding of the handicapped child. Both rejection and over-protection have deleterious effects on the developing personality of the individual.

Parents of the hadicapped resort to pass on their children to residential institution due to many reasons. Some look upon the residential special institutions as a penacea to all the maladies surrounding the handicapped. They wish and hope that the institution will use some magic formula to offset the organ inferiority of the child and translate it into a normal human being. A few approach the institutions to escape from the drugery surrounding the care of the handicapped. Surely, this is a form of escapism on the part of such parents.

Confining to the residential institution, the handicapped confronts further challenges in his individual and social life. The special institution spatially separates the handicapped from the rest of the society. Since the handicapped interacts mainly with other handicapped individuals in the institution he learns a mode of communication and pattern of adjustment peculiar to the handicapped who share the same organ inferiority. New norms developed among the handicapped individuals who are seggregated from the society at large and confined to interact among themselves. In short a new sub-culture ensures among the individuals confined to special residential institutions. This subculture gets consolidated in the course of time and removes the handicapped farther and farther away from the general population in sharing the culture. This leads to condition of cultural marginality. In other words, the handicapped share membership in multiple societies and this condition leads to certain incongruence of his role behaviour. This incongruence contributes to role-conflicts among the institutionalised handicapped.

Social Marginality and Personality Development : A handicapped child has all the potentialities of a non-handicapped except in those spheres where his handicap really places some limitations. However, parents and others tend to make wide generalisations about the capabilities of the handicapped which are unwarranted and unrealistic. They hesitate to confer on the handicapped responsibilities and roles which the handicapped are capable of. Hence, there is a discontinuity between the individuals personal attributes and the roles assigned to him in the society. Perception of this discrepancy between his self and the social expectations contributes to tension and discomforts on the part of the handicapped and consequently his behaviour undergoes some change. Incongruence between personal expectations and the role ascribed in society constitutes a condition for social marginality (Dickie-Clark, 1966) in the case of handicapped individuals. This social marginality is perceived not only by the handicapped individual but also the society at large.

The degree of social discomforts experienced by the handicapped varies from individual to individual. When severe, it leads to identity crisis. When moderate, it drives the handicapped to certain compensatory strivings. Social marginality induces contradictions in self-image of the handicapped. These contradictions are further reinforced by the ambivalent and inconsistent feelings and relationships the handicapped experiences in his interaction with others. The socially marginal receives a variety of cues in his interaction with others that he is considered to be socially odd. This may contribute to a flawed self-image on the part of the hadicapped. The foregoing considerations suggests that the handicapped may show certain symptoms of disturbance in his personality.

In order to verify this speculation the author undertook an investigation of institutionalised acoustically handicapped adolescents. The study involved 34 acoustically handicapped adolescents confined to the Municipal Special School for the Deaf and Dumb, Coimbatore. There were 23 boys and 11 girls in the sample. Their age ranged from 12 to 18 years. Rorschach Ink Blot Test (Rorschach, 1921) was administered individually to the subjects by the investigator. The protocols of the subjects were subjected to analysis on the lines suggested by Exnor (1964).

Of the 34 Ss administered with Rorschach, only 26 had produced responses which could be meaningfully interpretted; the protocols of 8 Ss did not lend themselves towards any meaningful interpretation since there were only a few obsolete responses. This suggests that approximately around one-fourth of the Ss have not adequately developed their personality or communication skills or both. The protocols of the remaining 26 were further analysed. The analysis reveals that most of the acoustically handicapped remain to be conventional in their personality, have low self evaluation, have high fantacy life, experience pain, have low level of awareness of others and show low level of strivings for integration they have simple psychological operations.

The body image of these Ss were evaluated using the responses given to the Rorschach Cards were further analysed using the scheme propounded by Fisher and Cleveland (1968). The analysis shows that the body image of the acoustically handicapped lack assertion of boundary definiteness. This shows that the acoustically handicapped feels that his body exterior is of little protective value and could be easily penetrated.

The results of the study confirm to the expectation that the acoustically handicapped do experience certain distortions in personality. It is suggested that this distortions may be due to the inferiority feelings and complexes on the part of the handicapped, inconsistency and ambivalent relationship between the parents and the hadicapped children, and social marginality of the institutional members. It is to be recognized that the factors listed could be easily manipulated and controlled by the conserted effort of the individual and the society.

Fostering Creative Development of the Handicapped : Admittedly a physically handicapped need not necessarily run in to personality distortions. A physical handicap leads to problems only when the individual accepts it as a condition of inadequacy. The proolems of handicapped are more due to learned helplessness reinforced by the individual and social factors. Indeed, an organ inferiority is not a barrier to realising potentialities of the individual. It has no direct bearing on the being.

The individual and society should learn to accept the organ

inferiority as one of the several individual differences seen among people. The inferiority should be accepted in proper perspective. Innovations in the technology of special education have produced effective methods and techniques of teaching the blind, deaf and dumb. Gadgets could be substituted for the weak organs. It is possible that the acoustically handicapped and visually handicapped could be brought much nearer to the level of competence achieved by the 'Normal children' by exploiting the technological advancements these days. In fact, a physically handicapped is more favourably placed in life in terms of psychological infrastructure compared to a mentally handicapped. The family, school and society should avoid showing disproportionate love or rejection to the handicapped on the basis of wide generalisations. A handicapped should be looked upon a 'normal' individual in all the senses of the term except in those realms where the physical characteristics place some limitations on the capability of the individual. As Rogers (1971) has rightly emphasised, the degree to which one can create helping relationships which facilitate the growth of others as separate independent persons should be taken as a measure of the growth of his own self. Let us examine 'ourselves' in this light with regard to what we could do for the handicapped fellow beings.

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The Physically Handicapped in the Handicapped Society

ARIF HASSAN

The year 1981 was observed as the 'International Year of Disabled'. It was with a view to create awareness in the society regarding problems of handicapped and to launch welfare schemes for them. Thus, several programmes for their rehabilitation and general welfare have been taken up by various national and international agencies. It is gratifying to note that society has of late tried to bring succour to the misery of this neglected section of the population, notwithstanding, the fact that incidence like Bhagalpur blindings occurred in the same year.

Till the beginning of this century, the physically handicapped were left to their destiny. Only a few philantheropic institutions tried to bring some relief to them in the form of charity. The two world wars and the development in science and technology over the years nurtured a concern for concerted efforts for rehabilitating this neglected humanity all over the world. The constitution of India, too, has given adequate attention over this problem. It has thus accorded the disabled and equal right to have adequate means of livelihood, to secure education and work and to protect themselves from undeserved want. The State is, therefore, expected to provide adequate opportunity for obtaining medical treatment, education and training, gainful employment or resettlement in employment and social rehabilitation so that they are accepted by the family and the community to which they belong.

There are only rough estimates of the number of disabled across the globe. According to the United Nations global estimate about 10 to 12 per cent of world population are disabled. UNICEF (1981) estimates that in 1975 three fourth of the world's disabled were in third world countries. By A.D., 2000 four fifth of the disabled would be in these

countries. In India, the national sample survey in 1959-61, 1969-70, and 1972-74 made attempts to compile information on disability, but no reliable figures emerged for want of clear definition. Rough approximation indicates that nearly 5 per cent of India's population, i.e. about 30 million people, are handicapped. According to Luthra (1974), the country had about 10.6 million physically handicapped persons exclusive of the lepers and the mentally retarded. Among them, 4. 4 million are blind, 2 million deaf and 4.2 million orthopedically handicapped.

The number of handicapped persons is increasing very fast. Luthra (1974) records a rise of 40 thousand deaf and one lakh orthopedically handicapped persons every year. According to the survey conducted by the Indian Council of Medical Research in 1975, the country could be said to have 8.4 million blind in a total population of 600 million.

A considerable section of the physically handicapped consists of the children. About 4 lakh out of the total 4,390,000 blind estimated by the Ministry of Education in 1967 are said to be of school age. Among the 2 million propulation of deaf, 20% are said to be children.

The distribution of the physically handicapped varies over regions. According to the National Sample Survey in 1969-70, the number of the handicapped persons is highest in the states of Madhya Pradesh and Punjab respectively being 6.27 and 5.00 per 1000 persons. The state of Bihar comes next to them being 4.97 per 1000 persons. The States of Gujarat and Maharashtra have the lowest incidence of handicap of respectively being 2.02 and 2.73 per thousand persons.

Despite the fact that disabled constitute a large segment of our population and the political ideas of liberty, equality and fraternity apply equally to them, the Indian society has yet to gear up its resources to meet their urgent needs. Studies which have evaluated various rehabilitation and welfare programmes for the physically handicapped persons generally lament over the 'blindness' of the society in this respect (Mandal, 1979).

The plight of the disabled could be well imagined if we just note that there are only 127 schools in the country catering to the needs of 400,000 blind children and only 73 schools

for 300,000 deaf children. One may then visualise how miserably short we are in organising and providing services to the handicapped in other aspects of life.

Inamdar and Paranjpe (1981) have made a detailed study of the social welfare programmes for the physically handicapped in India. According to them the welfare services are hamstrung by inadequate finance. Allocations are regarded as 'consumption expenditure' with the connotation that they mean a drain on the economy. The Third Plan, no doubt, called for investment in 'human resources' but this is not seen in practice and the welfare schemes of the handicapped are still in essence seen as measure of charity.

While evaluating the rehabilitation services Inamdar and his associates (1981) notes that "there is acute shortage of personnel specialising in the different aspects of rehabilitation and therefore the need to train qualified professional staff has become an important need of the rehabilitation programmes." They further observe that "the services of the trained personnel are limited to a section of the urban society only". While discussing the education and vocational training aspect of the handicapped they feel that "there is need to establish an extensive network of educational and training institutions since the existing institutions have limited capacity." In India, little progress has been made in the manufacture of prosthetic appliances. Although some appliances for the orthopedically handicapped are produced in the country these are beyond the reach of the poor. Nevertheless some efforts have recently been made to bring appropriate technology into the field.

The Government of India, has been awarding post-matric scholarships to the physically handicapped since 1955. In order to ascertain whether this scheme made any significant impact on them, Mandal (1979) conducted a survey study in Bihar. He pointed out that though the scholarships has enabled the handicapped recipients to take up higher education, their number has been rather small over the decades. The reason enumerated by him include lack of information about the scheme, ignorance about the educational facilities, concentration of institutions of higher education in certain pockets of the State, etc. The study further notes that in the society not much change has occurred in people's outlook for them. Mandal

(1979) observes "Improper behaviour of teachers, reluctance of employers to employees the beneficiaries and indifference or ridicule of neighbours are indicative of the fact that educational achievement and employment have not yet been able to wear off the social stigma attached with the physically handicapped".

It is time now we should fully realize our responsibilities for this suffering segment of the society and come out of the handicaps which have resulted in their gross neglect over the years. It is urgently required that extensive mass publicity should be made to make people aware of the preventive measures of disease, modern means of medical treatment should be adequately expanded, educational facilities for blind and deaf should be extended to the remote areas, and adequate attention should be given for their job placement.

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Victims of Physical Handicap and Their Psychosocial Problems in Indian Society

K. P. KRISHNA

Introduction

A democratic society requires that every member should have a 'free access' to opportunities as well as a chances to fully participate in community affairs. The preamble to the Constitution of India promises to secure to all its citizens : "*Justice*, social, economic and political . . . . *Equality* of status and of opportunity, and to promote among them all *Fraternity* assuring the dignity of the individual and the unity and integrity of the Nation". The concept of the dignity of the individual would seldom be fully realised without paying attention to the handicapped, unless they are given special facilities so as to secure for them "equality of status and of opportunity". The Directive Principles of the State Policy, lay down, among other things:

(i) "The state shall strive to promote the welfare of the people by securing and protecting as effectively as it may a social order in which justice, social, economic and political shall inform all the institutions of the national life" (Article 38).

(ii) "The state shall, within the limits of its economic capacity and development, make effective provision for securing the right to work, to education and to public assistance in cases of unemployment, old age, sickness and disablement, and in other cases of undeserved want" (Article 41).

(iii) The state shall endeavour to secure, by suitable legislation or economic organisation or in any other way, to all workers, agricultural, industrial or otherwise, work, a living wage, conditions of work ensuring a decent standard of life and full employment of leisure and social and cultural opportunities" and so on (Article 43).

(iv) "The state shall promote with special care the educational and economic interests of the weaker sections of the people" (Article 46).

Although the constitutional provisions elaborate public assistance to the handicapped they are yet to be fully implemented. In spite of efforts made by the Government and certain voluntary agencies, a handicapped person is often treated as second grade citizen. Everybody seems to be concerned with his disability, not with his abilities. But it must be kept in mind that physically handicapped persons are not vocationally handicapped. They can be compared with "dust of gold" collected from the floor of goldsmith. When the dust of gold is processed properly, the real gold comes out which too has a selling value. Likewise, if physically handicapped persons are processed scientifically, the idea of placing 'right man to the right Job' can easily be achieved.

The need to focalise the victims of physical handicaps and their problems is an urgent one. If victims in the wake of their disability are left to themselves, in many cases it may lead to situations which would hardly be in the long-range interest of peace and tranquility in society. The apathy on the part of society may lead to conditions culminating into beggary, antisocial, suicidal or criminal behaviour. This underscores the need for effective rehabilitation programmes for the victims of physical handicap. Moreover, in most of the cases handicaps are the creation of man-made situations like war, caste and communal riots, dacoity, air and motor vehicle accidents, pollution, food and drug adulteration, industrialisation, modernisation, urbanisation, and so on. Thus society has a moral obligation to look after such persons who have been victimised by man-made perils.

Keeping the magnitude of the problem in the Indian social context, the present work looks into the concept, classification, and extent of physical handicaps ; the problems of the physically handicapped, in general, and their psycho-social problems, in particular ; and the role of social scientists in analysing their problems.

Concept and Classification

In a way, we are all handicapped—economically, socially, culturally, emotionally, or morally. Only the degree and

duration vary. "Deficiency, shortcomings, limitation, dependence in any respect of life for any duration, short, prolonged or continued, can be called as handicap" (Raiker, 1979). The nature of deficiency may be mental or material-complexes, lack of opportunity, lack of resources, family burden, social responsibilities and so on. 'Handicapped' is a broader term which does not mean all the time severely disabled. According to medical definition and from the functional point of view anybody loses one of the fingers of his hand, he may be called physically handicapped. He is just like a normal individual and except that he lost one of his fingers. This paper however deals with those physically handicapped who have problems.

The physically handicapped are those who have bodily defects such as the blind, deaf, dumb, the crippled, paralytics, etc. The physically handicapped may be divided into two main groups:

(i) The orthopedically handicapped such as paraplagic, hemiplegic, amputees, etc. and

(ii) the sensorily handicapped such as blind, deaf and dumb.

At present, the Government has recognised only three categories of physically handicapped, i.e., blind, deaf and orthopedically handicapped. There is a request from many organisations that mentally retarded, leprosy cured, should also be categorised as physically handicapped. They are, no doubt, physically handicapped but the matter is still under consideration with the Government.

Extent

Accurate estimates of the magnitude of the physically handicapped child are almost impossible because of a number of technical and practical limitations. 'The lack of a uniform definition of handicapping, inadequate diagnostic facilities in some areas, and the absence of a reporting system, all add barriers to accuracy in making a total estimate' (Roberts, et. al., 1960, p. 433). However, it is estimated that "450 million people on the earth suffer from some form of physical, mental or emotional impairment. . . There are approximately 90 lakh who are blind, 20 lakh deaf, 50 lakh orthopedically handicapped, 15 lakh mentally handicapped and about 65 lakh emotionally and socially handicapped in India" (quoted by Ojha, 1981). Earlier Sethi (1980) quotes that "there are about 250

to 300 thousand blind and deaf, 500 to 600 thousand orthopedically handicapped, and 2500 to 3000 thousand mentally retarded." Some idea about the seriousness of the problem in India can be had from the UNICEF statistics. It has been reported that "there are 2 million mentally retardates, 8 lakh blind, 5 lakh orthopedically handicapped and 2 lakh deaf children. These figures do not include milder forms of disabilities" (quoted by Singh 1980, p. 3).

It is thus evident that the proportion of physically handicapped is sizeable and efforts are being made by various agencies to assesss the magnitude of the problem in India and abroad.

Problems of Physically Handicapped Persons

Problems of physically handicapped are varied and have educational, emotional, social, cultural and psychological dimensions. Moreover, their problems vary from place to place, culture to culture as well as from individual to individual. The problems of the hemiplegic are quite different from those of quardiplegic or paraplegic. The problems of disabled housewives are different from those of married disabled men. The disabled children pose problems different from adults. The disabled persons living in rural setting have problems different from those living in cities and metropolitan areas. In brief, each disabled presents a unique set of problems which requires special attention to find out the solution.

It may be reiterated that most of the disabilities are man-made. Accidents, war, riots, adulteration, etc. are some of the causative factors which can be controlled in society. Prior to the crisis, the victim may be assumed to be normal in managing one's life adequately. Thus the handicap, particularly the acquired one, may be viewed as a crisis situation. It is a personal crisis in the sense that the victim must cope with the handicap and its impact for themselves. An accident on the road leading to amputation, an infectious disease leading to blindless, and similar situations may change his entire physical and social activities, attitudes, and personality. Needlees to add, the acquired handicap poses more problems in family and society as compared to the congenital one.

Physical trauma of victims often leads to emotional trauma. Some of the psychosomatic complaints include insomnia,

reduced appetite, gradual loss of interest in life, negative attitude towards self, family and society, insecurity, anxiety, depression inferiority complex, irritable personality, reduction in tolerance threshold, emotional instability. These may lead to family disharmony and ultimately to pathological behaviour.

This is not to say that such problems are inevitable. Manifestations of psycho-social problems may vary according to time, place, and the mental set of the individual. For example, illiterates, belonging to lower strata and coming from rural areas may face less problems than educated ones, belonging to high socio-economic strata and coming from urban areas where he has to face many physical and social barriers in day-to-day life. Similarly, an amputee sportsman, who has been leading earlier an active life may face more problems as compared with others. Likewise, youth may face more problems than those who are middle aged or settled in life.

Victims' family life is also disturbed. If the victim happens to be a bread-winner, the whole family is affected. If family members are aware of the fact that the victim will have a wheel chair throughout his life, their attitudes may change from favourable to unfavourable. They knowingly or unknowingly start neglecting the victim. Attitudes of family members are often expressed in their general behaviour. The victim would surely perceive this attitudinal change gradually. This also leads to negativism, complexes and even to suicidal tendency.

The atmosphere of continued frustration and rejection in the home makes room for a serious social maladjustment. The child may become a bone of contention between his father and mother who may frequently blame each other for his shortcomings. This disharmony between the parents makes the child's feeling of rejection even more acute. The brothers and sisters are also slow in accepting their defective sibling and may even be ashamed of taking him out with them for fear of being ridiculed by other children. It is the family, therefore, that needs the utmost help in learning to accept the physically handicapped child.

Social stigma plays an important role in isolating the disabled from rest of the community. It is a fact that the degree of stigma varies from place to place, community to community and also from country to country. In Indian society

this social stigma is often more as compared to other countries. The disabled persons are not accepted by society and people do not try to see the abilities but only disabilities. This attitude acts as a barrier in their integration into society. The problems of the handicapped, therefore, are not only due to their disability but also because of this social distance often maintained in society.

It is thus evident that the problems of physically handicapped are multifacet and the manifestations are varied according to personal characteristics, demographic attributes, tolerance-threshold and personality of the victim.

Role of Social Scientists in the Problem of Physically Handicapped

The physical handicap is a crisis for which the victim has to suffer his helplessness. This crisis curtails the will power of the victim and disturbs his overall adjustment. Handling of these problems is a difficult task and requires a joint endeavour by the family, community, medicalmen, psychiatrists, social workers, sociologists and psychologists. Since most of the manifested symptoms are caused by psychological factors, psychologists have a key-role in tackling their problems and placing them in job according to their skill, temperament, interest and aptitude.

The need of placing the right man to the right job is well accepted. It is, however, possible only when physically handicapped persons are first evaluated scientifically before their placement in any job. It may be mentioned in passing that the evaluation of physically handicapped persons is not the job of only one individual rather it requires a team approach where the services of medical experts, physiotherapist, occupational therapist, psychologist, social worker, employment officer, and so on can be put together. In other words, the physically handicapped persons must be evaluated medically, psychologically and vocationally using scientific methods.

The medical evaluation provides a guideline to what extent the functional capacity of the affected part can be improved either through surgery or through any other devices. Secondly, whether the prognosis is stationary or there are chances of future deterioration. The psychological evaluation plays an

important role in social, economic and moral rehabilitation of the victim. The psychologist tries to see the ability and not the disability. He tries to see "what is left now and presumes what he can do with the remaining functional parts of his body". Keeping this in view, he evaluates intelligence, aptitude, interest, skill, work traits, behaviour, adjustment problems of the victim. For this he uses standardised psychological tests. At this stage, it seems relevant to mention that it is not necessary that all the psychological tests are administered depends upon the nature and problems of the victim. But intelligence and aptitude tests are invariably administered to clients. It is only because the intelligence points out to what extent one can go and aptitude indicates in which area one can go. Vocational evaluation provides an opportunity to know the client's vocational strength and weaknesses.

It is thus evident that the motive behind evaluation is to find out the suitability of the job matching with disability so that the physically handicapped persons can be placed in gainful employment on selective basis.

During evaluation period regular counselling is needed. In some cases it has been reported that they accept disability as a challenge but in other cases they are all the time preoccupied with their own problems arising out of their disability. They will hardly concentrate on their job unless their personal, social, and emotional problems are taken care of. A psychologist makes effort to ascertain their adjustment problems. He is also concerned with personal and vocational counselling. Besides, in some cases parents also require counselling. In brief, psychologist by tackling their adjustment problems tries to overcome their many problems.

One of the roles of the psychologist to involve parents and teachers in assessing, teaching, training and rehabilitating of the disabled persons. He should also try to involve community agencies, religious leaders, community workers, and above all the family to tackle their problems in the best possible way. For this purpose psychologists may take up the help of media of mass communication. It is to be added that media of mass communication like television, radio, movies, newspaper, etc. have proved more effective in changing public attitudes towards national and international social problems.

Most of the physically handicapped persons approaching psychologists for diagnosis and guidance lack motivation to get proper treatment and live in society. This is due to frustration induced by personal, familial as well as social factors. Thus a psychologist has a role in restoring his confidence and interest in social activities and in life. Such persons rarely accept the reality. But in any systematic rehabilitative programme it does matter. Without proper motivation and acceptance of the reality, they can do little in life. Once the client accepts the reality, he can easily do certain jobs in spite of his limitations. At any rate, his level of aspiration should be brought to his reality level in the light of job opportunities. At this stage, it may be pointed out that the psychologist should not impose his thoughts and ideas, rather he should assist in planning the future of the handicapped according to his level of intelligence, aptitude, interest, temperament, skill, motivation, and personality.

The social scientist will have to play a major role to bring awareness among the masses, particularly those in rural areas. They will have to educate them that anybody at any moment can be affected by paralysis, leprosy, cancer, blindness, and deafness. Anybody at any time can meet an accident and lose his legs, arms, or any part of the body. So the problems of handicapped are not the problems of handicapped alone but of the community as a whole. Hence, everybody in society should share this responsibility so that the disabled can lead a meaningful and dignified life.

To conclude, the physically handicapped in Indian society face numerous problems—personal, familial, social and psychological. Problems vary with time, place and the individual as well as with economic conditions and social attitudes. Handling the problems of the physically handicapped is a difficult task and it requires collective efforts of the community and social scientists who can assist in evaluation, teaching, training and rehabilitation of the victim. Further, the Government should encourage voluntary organisations, hospitals, professional organisations and the like to undertake research in the problems faced in the effective rehabilitation of the handicapped.

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Section V

Rehabilitation and Education of the Handicapped and Socially Deprived

Introduction

The handicapped of any category needs proper rehabilitation and education in order to participate in the day-to-day life. The Government, social and voluntary organisations are fully aware of the programs and techniques of rehabilitation of the handicapped. The only lacking is the organisational effort, political will and financial resources. Similarly, social mobilization, the education and training programs are urgently needed which would enable them, their family and their community to articulate their needs. This will eventually assist the experts and professionals in assessing the overall community and population needs for rehabilitation services. Like many other categories of the handicapped the destitutes, socially and economically deprived also deserve attention from the larger section of the community. It is also the duty of the society to stop, discourage and prohibit the deviance and withdrawal by the members from the mainstream.

The aim of rehabilitation services should be directed towards creating awareness, changes in attitudes and analysis of social and environmental conditions. As a matter of fact, the disabled in the developing nations are dependent upon family and community. A planned effort to raise the resources from various chains like social, cultural and religious organisations is required to be made. Also a concerted effort through education and training could be helpful in lessening their dependence. This will amount to their participation in the social and community development.

The national policy for rehabilitation of the handicapped also recommends training and education of the disabled and proper administrative arrangement to involve the participation of the community. Such steps would help the victims in participating in the socio-economic advancement of the community and leading a life with dignity and respect.

This section of the book deals with the problems of the

children and integrated education for them, rehabilitation of the handicapped and the socially deprived. The first paper by Muriel T. Hirt attempts to eradicate the false conception attached with the hospitalization of the children. She also lists the programs provided by Wheelock College aimed at helping the hospital inmate children through active plays. She claims that play can influence a number of social, emotional and cognitive growth. Hirt also highlights the importance of interaction of children with other adults especially the parents which will lead to their adjustment in the hospital environments. Lastly, she emphasises the need of cooperation between child life worker and physical therapists, social workers, nurses, teachers and tutors.

In the second paper Anila Gangrade speaks about the rehabilitation of the handicapped especially the mentally sick. She discusses the needs and programs of rehabilitation and also stresses on the need for preventive measures. She further talks about different programs for vocational rehabilitation in order to exploit their skills. However, rehabilitation works should include working with family and community, in order to make attempts to change their attitudes. And also the rehabilitation should include psychological, vocational and social dimensions. She throws this task as an open challenge for the social workers for a detailed study involving lives in hospitals, family, ex-patient clubs etc. Lastly, she speaks of joint effort by psychiatrists, social workers, psychologists, nurses, vocational counsellors etc.

In his paper M. Seetharam discusses the need for integrated education for the handicapped. He speaks that the universalisation of education for the handicapped is a must in order to bring them into mainstream. The programs should include all mental, sensorial, physical and emotional handicaps. Though there is rise in the number of programs like 200 in 1982 against 32 in 1947, he further stresses the need for implementation of Article 45 of Indian constitution for putting them with normals. Seetharam also feels need for special arrangements for them. He also highlights the problems involved in administrative communication, training and appointment etc. He critises the privately managed schools and wants proper evaluation of the programs running for them. Lastly, he emphasises for promoting the integrated strategies for educating the disabled.

In the last paper with sociological approach M. Shehzad Hussain warns against revivalistic movement among muslim community. Having compared two religious organisations, i.e. *Jamaat-e-Islami* and *Tablighi Jamaat*, he holds the latter responsible for increasing backwardness in the community. This deviance from the mainstream, according to him, is harmful and fatal for both the community and nation. He emphasises on the proper social mobilisation of the community members in order to stop deviance from day-to-day life problems and wastage of human power and economic resources. He concludes that such fundamentalistic movement, if discouraged, would bring the community into the mainstream.

Child Life Programs in Hospitals

MURIEL T. HIRT

Many years of research in this field by authorities such as James Robertson, Emma Plank, Hugh Jolly and others indicate that hospitalization is a traumatic experience for almost all children.

Attempts to help alleviate this trauma began almost 30 years ago with the introduction of a few pediatric play programs. More hospitals today are providing these programs. Wheelock College is one of the few institutions training students in this field.

The goals of these programs include :

1. *To provide the hospitalized child with opportunities to participate in active play thus supplying optimal conditions for the continuation of social, emotional, cognitive and physical growth.* This concept is based on the commonly held idea that physical recovery is highly dependent on the patient's mental health, and that the emotional well-being of the child is greatly enhanced if he is allowed to take part in meaningful play activities. A more specific value of play in the hospital is that it is a familiar activity for most children and therefore is seen as a link between hospital and home environment. If the hospital is made as much like home as possible, we can assume that adjustment to hospital life will be easier.

An emphasis of this objective is also placed on the provision of *active* play. This is due to the fact that much of the life of a patient consists of being dependent. The child is made to conform to demanding and often nonsensical routines, he has little say in the manner in which his medical treatments are carried out or what treatments he must undergo, and often opportunities for self-care (such as feeding, toileting and bathing) are taken away from him. For a child who has just recently mastered skills allowing him to be more independent of adults, this experience is very threatening. However, the child can maintain

some of his feelings of autonomy if he is allowed to determine when he will play and what form his play will take. Therefore, depending on the child's mental, emotional, and physical state, it is considered important that the playroom itself be child centred, allowing the child to make his own choice from a number of activities, and that the Child Life Worker have no preconceived notions about what activities the child will take part in. Specific types of play that seem to give the child a sense of achievement and competence include crafts, play with blocks, construction kits and puzzles, and hobbies.

Another important aspect of the actual provision of play is that it is often the means by which the child expresses painful emotions he cannot verbalize. The Child Life Worker's role in this area has been called giving "emotional first aid". Like the Play Therapist, if the Child Life Worker can determine what conflicts the child is dealing with through observations of his play. She can facilitate the child's working through these conflicts by directing his play. Dimock has found that dramatic play, art, and messy play are especially suited for the release and mastery of emotions.

The child's physical development can also be enhanced through active play. If specific parts of the body must be exercised or restricted in movement, the Child Life Worker can devise activities that will aid the child in carrying out medical orders in a pleasant way.

Finally, participation in play increases the possibility that the child will develop peer group relationships while in the hospital. This is especially important for school age children and adolescents who obtain much of their support and sense of identity from their peers. Group formation is also crucial in hospitals serving long term patients, since an extended period without peer relationships hinders normal social development. Dimock cites dramatic play, games and music as being most successful activities for facilitating peer group development.

2. *To provide the hospitalized child with the companionship of one consistent, non-threatening adult.* This goal necessitates that there be at least one full time staff member in the play program and that person has nothing to do with administering medical treatments. This means that a play program staffed by volunteers or that is a responsibility added to the nurses' duties is inadequate.

The nature of the Child Life Worker's job allows her to spend extended periods of time with the children on a basis that is not hampered by rotating shifts or movement from one unit to another. This gives the Child Life Worker an opportunity to determine the individual child's emotional needs and give adequate support. For children under six, the support may be in the form of acting as a mother-substitute, especially if the mother does not room-in, or visits infrequently, and at times of separation from the mother at the end of a visit. For older children, the Child Life Worker will most likely give support be being a friend and confidante to the child ; perhaps by always being available and concerned listner, or by voicing some of the child's probably anxieties that he is unable to verbalise. For all children, the Child Life Worker can lend the actual support by being present during medical procedures.

By implication, the fact that the Child Life Worker is seen as a non-threatening adult means that the playroom will be considered a secure haven by both children and their parents.

3. *To encourage the maximum amount of parent participation in the care of their hospitalized child, and to provide support for the parents and other family members.* This goal developed from two concerns of providing optimal care for children, the first being that all patients have the right to be acknowledged as a member of a family. The inclusion of family members in the daily life of a patient is another means of providing a link to home life and provides a source of comfort when faced with the foreign environment of the hospital.

However, the importance of the presence of family members, especially parents, is even more crucial to child than to adult patients. It has been documented by Robertson and others that the major concern of the hospitalized child under five years of age is separation from parents. Due to an unrealistic sense of time and the dependence of the child on the primary caretaker for the satisfaction of his basic needs, the child feels he is being abandoned if his parents are not present during the majority of his hospitalization. This feeling of abandonment is so overwhelming that the child goes through stages similar to those of the grief process. If intervention does not take place, the child may be unable to invest himself in close, personal relationships later in life. Since regression is a common

occurrence during illness and hospitalization, children over five may also be increasingly dependent on parents.

To encourage parent participation, the Child Life Worker must first help parents recognize that they have the most complete knowledge of their child and therefore are the most likely to be able to meet his needs in this stressful situation. However, because hospitalization is an unusual situation, sometimes the parents will need explanations of the child's reaction to stress and how to help him deal with it. Secondly, the Child Life Worker must be an active supporter of the parents attempts to obtain rooming-in, unrestricted visiting and the permission to accompany children during medical procedures. As such, the Child Life Worker can be seen as a liasion between the parents and the medical staff.

Besides being a stressful situation for the child involved, hospitalization creates tension in all the family members' lives. The Child Life Worker can often be very helpful by just making herself available to listen to the parents' concerns and by showing sympathy. The emotional reactions to a child's illness of grief, anger, guilt and fear can be discussed in parents groups facilitated by the Child Life Worker. In addition, if the Child Life Worker feels the parents' or siblings' problems are too overwhelming for them to handle by themselves, she may provide the initial contact between the family and the hospital's Social Service Department.

4. *To facilitate the comprehensive care of the child.* This means the Child Life Worker must be an active participant in the interdisciplinary team that cares for the child. Thus the Child Life Worker provides non-medical observations of the child in a natural setting (the playroom) that will help the medical staff see the child as an individual rather than just a patient, and provides pertinent information for diagnosis and treatment. The observations may also uncover the child's unanswered questions and anxieties about medical procedures and his illness. If the Child Life Worker does not have the medical background to explain these points, she can refer the child to the appropriate staff member.

The Child Life Worker, in addition to working closely with physical therapists, and social workers, must cooperate with the nurses to provide total care for the child. If there is

adequate communication between Child Life Workers and nurses, the nurse can instruct the Child Life Worker on how to make the patient comfortable life and feed him safely, and explain medical procedures to him. The Child Life Worker can give the nurses information on child development and the effects of hospitalization on the child's behaviour can encourage play between the nurse and child and can act as a role model for the nurses' interaction with children.

The Child Life Worker also needs to work closely with the children's teacher or tutor. The Child Life Worker often has information about the child's interests that would be helpful to the teacher, while the teacher can suggest activities that can be carried out in the playroom and that will correlate well with the child's school work.

Rehabilitation of the Handicapped– With Special Reference to Mentally Sick

ANILA GANGRADE

"Rehabilitation" denotes to restore to a former capacity, to restore to good repute, to restore to solvency efficiency, to make fit to earn one's livelihood again. National Council on Rehabilitation in 1951 said, "Rehabilitation is the restoration of the handicapped to the fullest physical, mental, social, vocational and economic usefulness of which they are capable." Black (1964) has referred rehabilitation to those services which are designed to assist persons who had been psychiatrically handicapped, to achieve as high a level of adjustment on their return to the community, after an active course of mental treatment, as is possible in the face of their residual disabilities.

It is observed that though varied, almost all the definitions of rehabilitation have emphasised on the attempts to improve the effectiveness and work ability of the patient. In fact all the attempts at treatment starting from the patient's first contact to his return to the community, aim at the above. Thus rehabilitation starts from the very time of contact of the patients with the mental hospital.

The emphasis on rehabilitation of mentally sick has grown out of the gradual shift from "Special therapies" to the treatment of the whole person, involving his personal and social being also.

NEED FOR REHABILITATION SERVICES

1. *Social breakdown syndrome and rehabilitation.* Lengthy hospitalization and time consuming treatment of the mentally sick results in detachment from their community, their roles and their skills. This results into social breakdown syndrome. With the loss of skills, social roles and interaction with the

community the persons gradually loose self-respect and self-confidence. They acquire a new social role of a dependent patient and eventually become permanently disabled (Gruenberg, 1967).

Barton (1959) had also described a syndrome similar to social breakdown called as institutional neuroses and he also attributed it to the hospital life. However this does not mean that mental illness will disappear if hospitalization disappears.

Due to this complication, recent years have emphasised on putting in-patient treatment as the last resort. This to some extent prevents the complications arising out of hospitalization. There is the need of rehabilitation services in cases where hospitalization is a must.

These rehabilitative services which are needed to overcome the complications arising out of hospitalization should include proper arrangements for discharge of the patient, and minimizing the effects of social breakdown by giving him enough time and opportunities to revive himself. These include day-care centres, vocational training, gradual exposure to the community through day or night hospitals, follow-up services and adequate supervision.

The patient may be helped to ragain self-confidence and self-respect by giving him certain amount of independence and certain roles (akin to his original ones) to perform in the hospital.

2. *Reactions to Discharge and Rehabilitation.* It has been quite commonly observed that patients suffering from mental illness react adversely to discharge. This is mainly because of the protective, secure, demandless atmosphere of the hospital where majority of their needs are fulfilled.

Separation from such a secure, comfortable dutyfree atmosphere gives rise to severe anxiety in patients. Some time the reaction is so acute that the patients, symptoms reoccur as the discharge time approaches nearer (Lindemann, 1945).

Such reactions of mentally sick are not surprising as quite often the root cause of such illnesses is found in the patient's separation from beloved and the loss of their dependency needs. According to Schmate (1958), the basis of a psychiatric treatment is development of a healthy and satisfying relationship. Once such relationship is maintained and the patient

starts feeling satisfaction, security and protection, his symptoms are relieved. But as he realises that this is going to break, the patient can't face it again and develops severe side effects.

At such times, there is a need not to discharge the patient in such a way that the support to which he was accustomed is withdrawn suddenly.

The transitional period of the shift of patient from hospital to the commumity is very important. Rehabilitative services involving adequate time given to the patient to prepare himself for separation and readjust into the atmosphere and with people outside the hospital are very necessary.

Services like day-care centres, day and night hospitals, frequent home visits can help minimize the adverse reactions to discharge.

3. *Prevention of Mental Illness and Rehabilitation.* It is a general trend to terminate the case with his discharge from the hospital. Once a person is discharged very few effort are made to know about his post-hospital life. This results in relapses of the disease which is very commonly observed in mentally sick patients. There is a "rotating door" phenomenon which means that the same set of patients keep on rotating in the mental hospitals.

To avoid relapses and wastage of resources, patients' care should not end with their discharge from the hospital. Services should continue in the post-hospital life till the patient is rehabilitated into a successful life in the community.

Rehabilitation helps in the tertiary prevention of disorders, Tertiary prevention aims at reducing the residual effects of complication so as to prevent further occurrences of disease which is minimized by aiming at achieving fullest physical, mental, social, vocational and economic usefulness.

Services aimed at this should include effective follow-up where regular check-ups are done and residual symptoms if any are managed.

4. *Individual's Optimal Level of Functioning and Rehabilitation.* Rehabilitation of handicapped is a very broad programme and embraces the art and science of restoring the patient as far as possible to normal and to his maximum efficiency.

Provision of services, so that the patient may become a useful member of the society is important. Continuation of professional services through the post-hospital period, for as long as two years, should be a rule.

Rehabilitation aims at giving support to the person, helping him to get adjusted socially, vocationally, physically as well as morally and become a fruitful member of the society. Programmes of vocational rehabilitation therefore which include helping the individual to regain the earlier job or to find out the new one, helps in adjusting the individual to normal life should be started.

Various social skills, mannerism, expectations moral obligations are taught to the patient so that the person after discharge is easily accepted by the family and community at large.

Physical rehabilitation apart from treating the disease also aims at helping the patient to live with his symptoms. This includes helping the patient to recognise danger signals, to understand the events which typically precipitate difficulties. The rehabilitation programme provides emotional prosthesis at such times. It involves the patient's understanding of symptomatic danger signals, and his knowledge and ability to avoid aggrevating situations (Black, 1964).

All the above and various other efforts aim at maintaining the individual's balance and efficiency which is very important in order to rehabilitate him fully.

5. *Shift from Individual to Environment and Rehabilitation.* Until the middle of this century psychiatrists used to concentrate on the patient individually. The treatment of the mentally ill was mostly a one-man show of the psychiatrist and adequate attention was rarely given towards the physical and social environment around the patient (Mukherjee, 1973).

The concept of psychiatric community care has caused a fundamental shift in the pattern of management of psychiatric patient. This concept is mostly based on the realization that there is a definite interaction between psychiatric breakdown and the behaviour pattern of the family and that a sick family produces a sick person. Thus tackling of a psychiatric problem should start at family level.

Psychiatric community care includes prevention, care, after care and rehabilitation of the mentally ill in the community.

An assessment of the patients' home conditions and the attitudes of their relatives would be indispensible and the complete recovery of patient might depend more upon this than on the patient's clinical conditions.

The problem of after-care in India is mainly the problem of the management of the patient's circumstances rather than of his symptoms.

Importance of family both for treatment and rehabilitation has been realised. Thus rehabilitation programmes should include programmes of working with the family and community.

Greenblatt and Simon (1959) had also observed that deteriorated schizophrenia was the origin of an atmosphere in which the more healthy components of his personality had no opportunity to function. An essential component of the normal function of the individual is a constant and healthy interaction with his environment, particularly with the other human beings in his environment.

Rehabilitation, both in the hospital and out of it, must rely on the activities of normal living through which the healthy component of the personality can develop and the individual can work normally in the society.

TYPES OF REHABILITATION

According to Greenblatt and Simon (1959) rehabilitation of the mentally sick is of the following six types :

1. Psychological
2. Vocational
3. Family
4. Social
5. Community
6. Recreational

Psychological Rehabilitation

A person suffering from mental illness is generally seen to be deteriorated psychologically. He is fearful, anxious, tense, insecure and apprehensive. To resolve all these feelings is the first step of any rehabilitative programme. In order to start working for the rehabilitation of such an individual, resolution of all the above by providing support, affection and understanding atmosphere is a must.

Vocational Rehabilitation

Rehabilitation is often mistaken to be solely concerning vocational rehabilitation. This is because vocational rehabilitation constitutes an integral and an important part of all the rehabilitative programmes.

Vocational rehabilitation embraces :

(a) Vocational counselling which includes assessment of the client's abilities and interests.

(b) Vocational training: where the patient is given training in trade or profession.

(c) Job finding and placement : Jobs are commonly provided in collaboration with specific state, governmental agencies and through personal contacts.

Family Rehabilitation

Shift from individual to the family has led to including family also in treatment as well as rehabilitation. The problems of the family, their solution, provision of counselling services to the family etc. are included here.

Social, Recreational and Community Rehabilitation

For general adjustment of the individual in society, these services are needed. The person is taught various social skills and ways of adjusting in the community.

Educational Rehabilitation

Educational facilities in hospitals side by side teaching opens avenues for them to become independent, to channelise their pent-up energies, to get ways of expressing their thorough feelings and so on. These services are generally provided in the day-care centres. Various programmes are included such as art, craft, music, carpentry, language instruction etc.

SERVICES FOR REHABILITATION OF PSYCHIATRIC PATIENTS

After care, which is the formal help for rehabilitation given to persons who suffered from psychiatric illness are very few till today. These have been, however, isolated efforts, initiated by governments of different countries. It is observed that majority of efforts in this direction have been initiated by voluntary organization.

Few of the important rehabilitation programmes existing in United States of America are listed below :

Ex-patient's clubs

As the name suggests these are the clubs of people who had suffered from psychiatric disorder. The rehabilitative services for mentally sick have their origin in one such clubs, which was initiated in 1940 in New York.

These clubs comprise of the willing ex-mental patients to meet and solve their post-hospital adjustment and various other problems. The aim of these clubs is to provide the ex-patients a healthy and comfortable environment where they can learn to function as social beings. Such clubs are very few. The reasons for their limited growth according to Olshansky (1962) are :

(a) Diversity in the problem, personality and needs of patients.
(b) Trend in majority of people to forget the illness as soon as they are symptom free.
(c) Stigma attached to mental illness.
(d) Insufficient services and lack of professional help.

Day Hospital—Night Hospital

The day hospitals and night hospitals have emerged out of the complications created by the hospitalization. These services may be used as the complete substitute of hospitalization or during the transition period of adjusting the patient from hospital to the community and are important as the patient is not completely secluded from the community. In day hospital, the patient remains in the hospital for the whole day and goes home at night while the night hospitals, act the other way round. They are an ideal for treating the relatively mild mental disorders and give an opportunity to the patient to continue the job or his daily important activities alongwith the hospital treatment.

Short-stay Homes

Short stay homes go a step further to the ex-patient clubs, which provide in addition to the residential home with generally a professional person also. A number of ex-patients live together. The aim is to provide a sheltered social environment where the deviant behaviours are checked before they are shown in general community.

These aims at socializing or rather re-socializing the person in accordance with the community's expectations.

Services for Vocational Rehabilitation

These include various institutions providing vocational counselling, helping in getting a job, giving training and providing work at sheltered workshops.

Through sheltered workshops these patients learn various vocational skills in a protective atmosphere where they are closely watched and supervised. Gradually they learn various skills and when confident they are placed in various jobs outside.

Rehabilitation Centres

These emerged with the thought to provide maximum of rehabilitation services at one particular place. These centres are generally observed to be attached to the hospitals, where all the necessary services for the persons rehabilitation are provided. Generally there is a full team of psychiatrists, psychiatric social workers, psychologists, vocational counsellors and nurses.

REHABILITATION SERVICES FOR MENTALLY SICK IN INDIA

1970-1980 was designated as the 'Decade of Rehabilitation' by Rehabilitation International. In India, however, the services for rehabilitating mentally sick remain more on paper than in practice.

Because of the shift in the outlook of mental illness and mental hospital now we observe efforts for prevention and rehabilitation taking momentum. But whereas our Government is spending a fairly large amount of money on rehabilitation of patient's suffering from T. B., leprosy etc. there is practically little emphasis on the rehabilitation of mental patients. The reason is very simple, as it is because of the attitude of the community as a whole towards these patients (Malin, 1971).

In India, the rehabilitation of these patients in the community is the most challenging job for social workers, whereas on the one hand they have to work with the patient, while on the other to work with the community.

With the view of the enormity of problem there have been

meagre steps to cope with the problem. For these, the important ones are mentioned below :

1. *Hospital follow-up services.* Hospital follow up services are one of the most important services in India. These may be considered similar to the day-hospitals, where instead of the full day, the patient comes for few hours depending upon the need. These services have great advantage in terms of economy, in maintaining a close integration of the patient with his family, and in treating the residual or reoccurring symptoms. Almost all the psychiatric clinics have follow-up services with special days fixed.

2. *Working with patient's family and those indirect contacts with him.* In majority of cases, the most important outside contact is the patient's family. The relatives of patients are called and various issues regarding treatment and rehabilitation of the patient are discussed, and if necessary their help is sought. They are told about the illness and its prognosis. Their negative attitude (which is generally found) is corrected and they are made more aware of various aspects of the disease and their contribution for effective rehabilitation of such patients.

3. *Public education.* This is a first requirement in a country like India. Experts reach the community and arrange talks, seminars, conferences, and demonstrations. These activities, though indirectly related to the immediate rehabilitative need, are of importance in a long run. These help in enlightening the general public and breaking down the barriers between hospital and the community.

4. *Day-care centres.* Apart from few voluntary organisations, day care centres are attached to the hospitals. Almost all the hospitals providing in-patient services to mentally sick have a day-care centre. These centres aim at educative, recreational, social and psychological rehabilitation of the mentally sick.

5. *Sheltered workshops.* For vocational rehabilitation of mentally sick, various factors like attitudes of employers, employee, his family and community toward mental illness have to be considered, as they influence the acceptance, work and productivity of them.

As yet, there is a negative attitude towards such patients in India, it is a very challenging job to rehabilitate them. Thus with the result there are very few sheltered workshops in India.

Mental hospital Madras has set up a small industry for mentally handicapped.

6. *Day hospitals—night hospitals.* Formally there are no day or night hospitals in India. But informally such services are provided to the patient. This is carried out, depending upon the individual psychiatrist and on the convenience and willingness of the patient.

7. *Ex-patient's club.* In India as yet there are no ex-patient's clubs of mentally ill, except for the one suffering from the problem of alcoholic addiction. There is a club in Delhi with the name 'alcoholic anonymous'. This club aims at providing convalescent period to the ex-alcoholic patients.

8. *Rehabilitation centres.* Few hospitals in India have rehabilitation centres attached to the psychiatric departments. These centres have similar functioning as of those in other countries. There are psychiatrists, social workers, psychologists, nurses, vocational counsellors and other necessary staff fully responsible for the task of rehabilitating mentally sick. Services include, provision of emotional support, teaching social skills, vocational skills, recreational activities, family counselling, follow-up and the like.

The insufficient services of rehabilitation in this country can be attributed to various reasons. Among these the important ones are :

1. Lack of resources, both personnel and financial ;
2. Lack of motivation in patient; and
3. Negative attitude of people

For the success of rehabilitation cooperation from the people is a must. The first and the foremost task our country has to accomplish is imparting public education followed by tangible services.

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Integrated Education for Disabled Children–Concept and Administration

MUKKAVILLI SEETHARAM

Historical Evolution

Hitherto handicapped children have been mostly cared and educated in special day or residential institutions. Undoubtedly, the special schools have played a major role in development of technologies and approaches to education and care of different types of physically and mentally disabled children. However, these services are very limited in coverage and concentrated in urban locales. Nevertheless, in absolute numbers the growth of institutions for the disabled has been steady. For instance, by 1947 India had just 32 schools for the Blind and the number has risen to almost 200 by 1980. The number of schools for the deaf was only 35 by 1947, rose to about 120 by 1980. The number of schools for the mentally retarded was just 3 but rose to over 200 by 1980. Despite the striking advances only about 4 per cent blind and deaf children are in school. Probably less than 0.02 per cent mentally retarded children have an opportunity to go to school (Government of India 1981). This amply reinforces the arguments advocated for extensive expansion of educational opportunities for disabled children. Universalisation of primary education for all is a cherished goal enshrined in the Indian Constitution. Towards this end, as far as disabled are concerned, a major alternative is integration in normal schools.

Significance of Integrated Education

The endeavour for educating handicapped along with normal children, described as '*integration*' in India and '*mainstreaming*' in the United States of America, is an inalienable constituent of the wider global movement of 'normalisation'—a conviction that as far as possible disabled people

should share the opportunities for self fulfilment enjoyed by other people. In India too integration of the handicapped has been a prominent concern eloquently reflected in the policies, programmes and documents of this Government. The theme for the International Year of Disabled was FULL PARTICIPATION WITH EQUALITY. However, it remains to be seen to what extent this urge will be translated into action. The handicapped children placed in normal schools still form a small proportion of all handicapped children. The children placed in normal schools have been mainly those with moderate rather than severe disabilities, but all categories of disability are represented. This underscores the need for continued sustenance of special schools for the severely disabled children requiring specialised environment and facilities.

Concept of Integration

Integration of handicapped has been perceived, conceptualised and practiced in different forms and settings. According to the Snowden Working Party, integration for the disabled means a thousand things. "It means the right to work, to go to cinemas, to enjoy outdoor sport, to have a family life and a social life and a love life, to contribute materially to the community, to have the usual choices of association, movement and activity, to go on holiday to the usual places and to be educated upto university level with one's nonhandicapped peers".

The aim of integrated education for those who suffer from mental, sensorial, physical or emotional handicaps include offering the child the maximum opportunity to develop cognitive, scholastic and social skills to the highest possible level. But there are differences in the patterns and quality of care and education for the handicapped from country to country and even from region to region within the same country (UNESCO, 1973 : 13).

Forms of Integration

Three main forms of integration have been delineated. These are:

(1) locational integration; (2) social integration, and (3) functional integration (HMSO, 1976). Locational integration exists where special units or classes are set up in ordinary

schools. It also exists when a special school is built on or near the grounds of ordinary school. In Sweden, well known for its advances in integrated education, this form of integration is widely practised. Social integration occurs where disabled children attending special class or unit eat, play and consort with normal children, and possibly share organised out-of-classroom activities with others. The closest form of association, 'functional integration' takes place where children with special needs join, part time or full-time, the regular classes of the school, and make a full contribution to the activity of the school. This also provides for adaptation of classes which supplement the work done by handicapped children in ordinary classes. Related to this is a scheme of integrated education in vogue in India which requires extensive adaptations to a selected school, to appoint extra staff on the care and teaching side and to admit ali suitable handicapped children in the area who are then placed individually in ordinary classes.

Legal Provisions

In several countries there are legal provisions for integration of handicapped children in normal schools. The U.S. Public Law 9442 stipulates that schools cannot refuse a handicapped if integration is "deemed optimal for the individual". Similar provisions are available in France and United Kingdom. Section 10 of the Education Act 1976 stipulates that handicapped pupils in England and Wales are to be educated in ordinary schools in preference to special schools. However, in India there is no legislation in favour of educational integration of the disabled children. Article 45 of the Indian Constitution envisages the provision of free and compulsory education for all children. What is needed is a comprehensive legislation encompassing various dimensions of rehabilitation such as education, vocational training employment, and social adaptation among the various categories of disabled children. Such a measure is a long overdue.

Special Arrangements

The main areas in which special arrangements will be required for integrated education of disabled children are:—

1. Special needs as regards transport, modifications to school buildings and furniture, and the provision of special equipment;

2. Personal assistance;
3. the needs for theraphy;
4. the need for information and advice to members of the school community, including the other children, in some cases their parents, and finally all the staff, specially the class teacher ; and
5. the need of some handicapped children for special teaching help.

Integration of a disabled child into the ordinary school must be studied from two aspects, academic and social. For academic adaptation and success the disabled child should, as far as possible, have a good level of intelligence, (b) strength to withstand the loneliness, the insecurity and the bewilderment, specially in the early period of joining the ordinary school; (c) a determination to try and progress, and (d) a positive attitude to learning. The child would have greater chance of success if adequately counselled for change in ways of learning, behaviour modification and empathy to needs and interests of non-handicapped pupils.

Central Sponsored Scheme

With a view to promote integrated education of handicapped and in consonance with national policy guidelines, the Government of India launched a scheme known as '*Integrated Education for Handicapped Children*' in 1975. In 1977-79 there were 64 schools in 8 States under this scheme covering a total of 415 handicapped children. In view of this lackadaisical performance the scheme was revised in 1980 incorporating additional incentives. In Delhi this scheme is being implemented in seven schools managed by the Delhi Administration and in fifteen primary schools under the Municipal Corporation of Delhi.

There are a total of 2444 handicapped boys and girls receiving education in normal schools in Delhi. These include 113 handicapped students in 84 schools run by NDMC, 508 students in 188 schools run by MCD and 1823 students in schools run by Delhi Administration and aided/unaided schools. Disability-wise break up of these students is however not available. Of these handicapped students only a small proportion numbering 90 are covered under the Integrated Education Scheme for Disabled Children, while the rest totalling 2354 do not receive any additional benefits other than those available to normal children.

Administrative Evaluation

There are problems of administrative communication and inter-departmental coordination hamstringing the implementation of this novel scheme. In several places qualified resource teachers are yet to be appointed for the benefit of disabled pupils. Given the range of structured incentives for the handicapped students, the teachers and the educational administrators, one wonders why the scheme is yet to break much ground and surge ahead. The very fact that only a trickle constituting 3.82 per cent among the total handicapped students are covered under this scheme speaks volumes for its tremendous potential. Further reinforcing this optimise is the reality that only about 22 schools out of a total of approximately 2000 schools in Delhi are covered by this scheme. At the same time it is intriguing that none of the privately managed schools have taken up the scheme. All these aspects need to be probed. One difficulty in the availability of trained manpower to teach disabled pupils in ordinary schools. The training of trainers and resource teachers through orientation courses, special capsule and formal educational programmes has not picked up sufficient momentum. It amply underscores the need for adequate attention to the salient dimension of man-power development.

Educational institutions in India are managed by a number of agencies; viz., the local self-Government, the Central Government, the State Government and private agencies. Hence the question of administrative coordination assumes importance with regard to success of centrally sponsored schemes. A great deal of persuasion and effort on the part of the nodal department is necessary in popularising the scheme. But the practice seems to be to the contrary. There are problems of mutual distrust, status differentials and lurking doubts, besides the customary red-tapism coming in the way of successful implementation of this programme. Another pertinent issue is to what extent the local bodies and state governments would be willing to provide matching grants for continuation of the central scheme after five years or would it turn out to be similar to the plethera of abandoned schemes witnessed in the past due to resource constraint and lack of interest. As the scheme envisages considerable investment in terms of provision of special equipment and special resource rooms for disabled

children besides other expensive adaptations, the aspect of long-term planning assumes importance. For periodic concurrent evaluation through feed-back suitable monitoring system has to be devised.

There is a need for provision of information and advice about the disabled children to the members of the ordinary school community. Likewise the normal students and staff have to be counselled accordingly. The person most in need of information about medical and educational problems is the class-teacher. Unfortunately these aspects have not received adequate attention in the integrated schools.

In final analysis, while single factor may initiate the damaging sequence in many cases of handicap they are always enhanced and reinforced by other factors. The implications of contemporary research are influencing the educational practice to the extent that there is no need for waiting for development of special schools for those with minor structural or functional handicaps, but instead extend integrated care and compensatory stimulation in the optimal learning period in ordinary schools. Though a beginning has been made much more needs to be done to promote integrated strategies for educating the disabled.

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Handicapped in Indian Society: A Sociological Interpretation

M. SHAHZAD HUSSAIN

The paper deals with the impact of 'fundamentalistic movements' upon the Muslims of rural areas. Fundamentalism, revivalism or the so-called 'reform movements' are causing a number of handicap to the Muslim community especially the rural poor illiterate masses. These are proving to be instrumental in keeping the community backward, illiterate, traditional, conservative and fatalist. Which in turn are posing multi-dimensional problems for the betterment of the community and the national development as a whole. These people are being deprived of taking modern education because of dogmatic preachings and religious ethos followed by age old obscurantism by the fundamentalists which keep them away from the mainstream of life.

We laughinghly talk about the terms 'handicapped', 'disabled', 'impaired' for those who lack some of the organs of their body either by birth or by accidents etc. But 'handicapped' does not mean only those who are physically disabled but those who are poor, illiterate, unexposed to modernity, technology, and are deprived. Although those who are physically disabled deserve more attention, sympathy from the larger room of the society, likewise, those who are socio-culturally deprived also deserve the same one way or the other. Socio-cultural deprivation leads to illiteracy, maladjustment in their daily lives and in the society as such causing over all backwardness to the community.

The present study is based on a field-work undertaken in the rural areas of Purnea district of North Bihar because of its typical socio-cultural background. Purnea has more than one-third of its total population as Muslims : the proportion is a little more than the overall average of such proportion to the country's total population, and about two-fifth of them live in rural areas

(Siddiqui, 1978). It is a predominantly agricultural society having feudal background with a very high rate of illiteracy and extreme poverty.

Fundamentalistic movements are on the increase now-a-days as compared to past in the rural areas of Purnea. The revivalist organizations i.e ; *Tablighi Jamaat* and *Jamaat-e-Islami*, have been trying to consolidate their respective holds in these areas. These are influencing the Muslims in their socio-cultural and economic activities. As a result of which the relationship between *Tablighis* and *Non-Tablighis*, *Jamaatis* and *Non-Jamaatis*, *Tablighis* and *Jamaatis* and that of *Hindus* and *Muslims* are also undergoing change gradually.

The villages under observation did not show any profound sign of religiousity until 1970. It was only in 1971 when a group of *Tablighis* from all over India held a State level *Ijtamah* at Araria Court (a sub-divisional town). As many as 10,000 people predominantly illiterate poor peasants from the nearby villages came to attend the *Ijtamah*. Some booklets, religious books like 'Falah-e-Din-o-Duniyan' and other 'Tablighi literature' were distributed to the participants free of cost by the organizers apart from preachings which lasted for three days. It is interesting to note that even the women as well as children came to listen to them. From 1971 onwards usual local level 'Ijtamahs' are being organized in the nearby villages almost once a year. As such it spread over in all the surrounding villages. The *Tablighis* preach door to door, they organize weekly programmes known as *Gasht* in order to keep the momentum alive among the followers, in all the villages and try to convince the rural poor to come to the mosque and Tablighi fold. Mostly they talk of self-purification, life after death, rewards and punishment for the deeds and misdeeds, quote *Hadith* and *Quran*. The approach is purely 'other worldly' thus making people alienated (Huq, 1980) from their lives, families, non-followers and ultimately the larger room of the society. The emphasis is on purification for which a 'Tablighi' is supposed to go out for 'Tabligh' for weeks, months (commonly known as Chilla : a forty days time). They even go to distant places for 'Tabligh' at their own cost for their own 'egoistic pleasure, (Huq, 1980). For the purpose of Tabligh even they take debt, from the money lenders, get their land mortgaged and even sell their land

no matter what mere land holding they have. It is interesting to note that one of the 'Tablighi' left for Chilla to Delhi with all the belongings he had, after Delhi he proceeded towards Hyderabad for which he was in need of money. He wrote to his wife to get the land sold, whereas he was a marginal farmer. These 'Tablighis' even don't think of their family welfare and this is how the economy is being deteriorated in this way. On the other hand they hardly care for their livelihood as such and become fully fatalist. In their view, the modern man is frantically after money, sex and power which must be eliminated fully. According to them men must surrender themselves to God completely and absolutely as emphasised and laid down in Holy Quran (Huq, 1978). Since Tablighi make people realize that every one has committed innumerable sin and crime by deviating from the path of Islam, for which one is bound to be severely punished after death. Thus sense of guilt and unwarranted anxiety forces them to become 'Tablighi.' Self-purification by offering Namaz at least all the five times and getting away of this worldly affair serve as the most effective check against the danger of self's getting lost into the world of evils.

It is observed that the poor and illiterate Muslims are much more attracted by this movement as they are ignorant and even don't know the A, B, C, of Islam and its tenets. Contrary to this only a negligible number of rich people become Tablighi. The rich ones who go for 'Tabligh' usually have had a dark past, who have committed a lot of sins and crimes in their social life, mostly the socially hated people. They come to the Tablighi fold as they find an escape. It is worthwhile to note that one of the notorious rich man joined this movement only when he was rebuked by every one in the society. In the present study almost 100 persons were interviewed and out of which only a handful number of ten persons were rich people. All of them were the socially hated people who either grabbed some one's land or committed heinous crime even rape and murder or the money lenders. These people became staunch 'Tablighis' and conservatives as well. The 'Tablighi' movement is causing a number of problems to the Muslims especially the economic activity of them are being fully shattered. The whole idea remains to purify oneself for a better life after death. One of the informant told that a 'Tablighi' was so much horrified by the 'reward

and punishment' theory that he lost his mental balance and became mad and died after a few months. It is further observed that only they oung and uneducated, mostly rural poor are attracted more by the movement than the old ones. They become staunch 'Tablighi' in the beginning so long as there is reinforcement by way of weekly programmes and 'Ijtamahs' etc. However, the old one's remain 'Tablighi' mostly, who generally happen to be socially hated and bycotted ones having the history of a dark past.

'Tablighis' are deliberately and completely isolated from politics and rest of the world (Farooqui, 1971). They fully withdraw from the society. They do not take interest on loans, even do not try for a better livelihood rather spend what they have for the 'Tablighi' activities. They are dead against English and Modern education and even the Government aided Madarsas (institutes for religious education) which according to them sow the seeds of irreligiousity. They discourage Government jobs and prefer to do their own occupations. They send their children to purely religious Madarsas even out of the State, like Deoband, Saharanpur, and Azamgarh etc. but not to the Government Schoolls at all. One of the Tablighi withdrew his children from the Government aided Madarsa and sent them to Deoband. On the other hand they become so much conservative that strict 'purdah' is observed. Girls are not supposed to go out of the house. However, they are being taught by the Maulvis at their homes especially about Hadith and Quran and some writing ability. As soon as they attain puberty they are married i.e, early marriage is encouraged. At times during Ijtamahs mass marriage takes place. Recently during my stay there, a mass marriage took place in which as many as 200 girls were married on the marginal dower (Mehar Fatimi being 10 Dirhams). Dowry unlike 'non-Tablighi' Muslims are not practised. This positive development is insignificant. These 'Tablighis' are against their own community members and are prejudiced against the 'non-Tablighis.' According to them neither the 'non-Tablighi' nor the Jamaat-e-Islami people are true Muslims ; the Jamaat is drifting the Mulims away from their right path and is a power hunger party not a religious movement at all. But there is no tension of Hindu Muslim as such because of Tablighi movement. As the 'Tablighis' either withdraw fully from the society or keep themselves away from the non-Muslims.

According to the Hindus, 'Tablighis' are least worried about the Hindus and are isolating themselves from the society. An interesting development took place in a village when only by seeing the 'Tablighi' affair, one Hindu money lender (a Banya by caste) left taking interest from his clients, but it is an exceptional case. However, it reflects the changes therein.

On the other hand, the Jamaat-e-Islami is said to have its hold mostly in the urban areas. This is because of the fact that only the literate, educated and well off people can become the member of Jamaat. They are however, peneterating in the rural areas now-a-days. They do hold Ijtamahs regularly and have a bureaucratic structure of their organization. The village school teachers, educated persons and mostly the economically well off who happen to be educated ones become the followers of Jamaat. They distribute various kinds of literature in different languages including Hindi and English in the rural areas too. It is interesting to note that even the non-Muslim elites do attend their Ijtamah. The Jamaatis mix with non-Muslims during festivals and other ceremonies. Whereas 'Tablighis' rarely go to non-Muslims on any occasion. As per my observation the relationship between the Jamaatis and Hindus are quite cordial (both the Jamaatis and the Hindus who are in contact with them claim the same). But there is polarization among the Jamaat and Tablighi people. Jamaatis consider Tablighis as obscurantists who are diverting the Muslims from the mainstream of life. On the other hand, Tablighis claim them as a purely pseudo-political organization which has different colours at different places and countries. As in Pakistan it is a purely political party, whereas in India especially Kashmir it is a rightist militant wing (Jamaat-e-Tulba) and in the rest part of the country it is simply claiming as reformist movement. Although Jamaat-e-Islami is not affecting the economy of the rural Muslims the way the 'Tablighi' do but it is obviously harming the other way.

Revivalism promotes chain reactions at regional and still lower levels resulting in a frantic search of one's local cultural pedigree. The sudden awareness of one's great past leads to the process of rediscovering of golden era. (Gangadharan, 1970). The leadership with its traditional role spread the message of revivalism, providing faulty perception to the ignorant and

illiterate masses. Among the poor and weaker sections of the society a false consiousness is being implanted by the traditionalist leadership by using revivalist and religious appeals. People's perception, good or bad, in a situation depends upon how it affects them.

In the light of the present study it is clear that the revivalist movements are hampering the cause of the community and the national development. Revivalism is proving to be a handicap to the rural poor Muslims. This kind of movements must be discouraged by the members of the Muslim community as well as the Government for the larger interest of the community.

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